

Exhibit 10

REPORTER'S RECORD
VOLUME ____ OF ____ VOLUMES
TRIAL COURT CAUSE NO. 241-1251-08

THE STATE OF TEXAS * IN THE DISTRICT COURT
 *
VS. * OF SMITH COUNTY, TEXAS
 *
DEMONTRELL LAMAR MILLER * 241ST JUDICIAL DISTRICT

JURY TRIAL
NOVEMBER 3, 2009

On the 3rd day of November, 2009, the following proceedings came on to be heard in the above-entitled and -numbered cause before the HONORABLE JACK SKEEN, JR., Judge presiding, held in Tyler, Smith County, Texas;

Proceedings reported by Computerized Machine Stenography, Reporter's Record produced by Computer-Assisted Transcription.

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REPORTER'S NOTE

Uh-huh = Yes - Affirmative response

Huh-uh = No - Negative response

Quotation marks are used for clarity and do not
necessarily indicate a direct quote.

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1 P R O C E E D I N G S

2 (Reported by Steve R. Awbrey, CSR:)

3 THE COURT: All right. We're on the
4 record in Cause Number 241-1251-08, State versus
5 Demontrell Miller. State and defense counsel are
6 present. Defense counsel is present. The defendant is
7 present before the Court.

8 Mr. Bingham, I believe, your witness is
9 here, correct?

10 MR. BINGHAM: Yes, sir.

11 THE COURT: What's his name?

12 MR. BINGHAM: Dr. Harry Wilson.

13 THE COURT: We're outside the presence of
14 jury, of course, and I believe Mr. Thompson just said
15 something to the Court about needing a 705 hearing.

16 MR. THOMPSON: No.

17 THE COURT: You're not going to need a
18 705?

19 MR. THOMPSON: No.

20 Are you ready for the jury then?

21 MR. BINGHAM: Yes, sir.

22 THE COURT: Ready for the jury,
23 Mr. Thompson?

24 MR. THOMPSON: We are, Judge.

25 (The jury entered the courtroom.)

1 THE COURT: Be seated, Ladies and
2 Gentlemen. Thank you.

3 All right. Mr. Bingham, if you would
4 call your next rebuttal witness.

5 MR. BINGHAM: Dr. Harry Wilson.

6 (The witness entered the courtroom.)

7 THE COURT: Dr. Wilson, if you could,
8 sir, raise your right hand for me, so I can swear you in
9 as a witness in the case.

10 You solemnly swear the testimony you will
11 give in the cause now on trial before the Court, will be
12 the truth, the whole truth, and nothing but the truth,
13 so help you God?

14 THE WITNESS: Sir, I so affirm.

15 THE COURT: Thank you, sir, very much.

16 If you'll come around and have a seat
17 right there in the witness stand.

18 If you could, Dr. Wilson, as you know,
19 you can move that microphone around and push it where
20 you can stay right up on it and speak right into it for
21 us.

22 THE WITNESS: Could I ask for a cup of
23 water?

24 THE COURT: All right. Mr. Bingham, go
25 ahead.

1 HARRY WILSON, M.D.,
2 having been first duly sworn, testified as follows:

3 DIRECT EXAMINATION

4 BY MR. BINGHAM:

5 Q Dr. Wilson, how are you doing?

6 A Okay. Thank you.

7 Q I know you flew in last night. You're
8 currently testifying in -- I guess you're on loan from
9 the Federal court in El Paso?

10 A I have a concurrent case, yes.

11 Q So you flew in last night and got in what time
12 about 1:00?

13 A Approximately, sir, yes.

14 Q What we're going to do, we're going to start
15 off by kind of telling the jury first, what do you do
16 for a living?

17 A My name is Harry Wilson. I am a pediatric
18 pathologist who lives and works in El Paso, Texas.

19 Q Who do you work for?

20 A I work for Pathology Associates of El Paso,
21 which is the pathology group that supplies pathology
22 services to the Providence Memorial Hospital in El Paso,
23 a private community hospital.

24 Q So you don't work for a county or a state
25 government?

1 A No, I do not; although, I'm on the medical
2 staff of the county hospital, and I'm on the faculty of
3 Texas Tech School of Medicine in El Paso. But both of
4 those are voluntary positions.

5 Q So you will be -- so you will not be -- do you
6 charge to come down here and review documents and
7 testify? If called, do you charge anyone?

8 A Well, no, I make myself available to review
9 material on cases as a public service for my own
10 perspective.

11 Q So there will be no -- you don't charge any
12 fee to do that?

13 A No. My expenses are met for plane tickets.

14 Q We pay your way down or the defense would pay
15 your way down. Whoever asks you to come testify, but in
16 other words, you don't work for like University of Texas
17 that will be submitting a bill, no bill at all will be
18 submitted other than plane tickets?

19 A That is correct, sir.

20 Q Where did you go to -- where did you grow up?

21 A Well, I was born in Illinois and grew up in
22 the Washington D.C. suburbs in Maryland.

23 Q Where did you go to undergraduate school?

24 A I went to Harvard College and Cambridge Mass.

25 Q Undergraduate degree?

1 A Yes, sir.

2 Q What was your undergraduate degree in Harvard?

3 A History of science and specifically history of
4 biology.

5 Q Where did you go to medical school?

6 A I went to the University of Chicago in
7 Chicago.

8 Q Did you do residencies, internships as a part
9 of the medical school?

10 A Yes. I actually did graduate work in
11 pathology. I actually taught -- also taught college
12 biology while I was a pathology graduate student, and
13 then I did both pediatrics and pathology internships. I
14 did pediatric residency and pediatric pathology
15 fellowships, so I had graduate work in pathology and
16 pathology internship and pediatric pathology fellowship
17 as well as my pediatric residency and pediatric heme
18 oncology residency or fellowship. I ended up with five
19 board certifications from that training.

20 Q What does it mean to be board certified?

21 A By experience and examination and training,
22 you're qualified in a particular area of medicine to be
23 able to take care of patients and render diagnoses and
24 call yourself by that particular designation whether it
25 be a pathologist or pediatrician or a specific specialty

1 in those areas.

2 Q What are your board certifications in the five
3 that you have?

4 A Well, anatomic pathology, which is the study
5 of the structural problems related to disease. Clinical
6 pathology, which is the study of laboratory issues
7 related to disease. Pediatric pathology, which is the
8 study of diseases and death in children. Pediatrics
9 which is the study and care, carrying for live children.
10 And pediatric heme oncology, which is the study and
11 evaluation and caring for children with cancer and blood
12 disorders.

13 Q Is there a difference -- so you are a
14 pediatrician?

15 A Yes, sir, and I moonlight as a pediatrician,
16 too, in an emergency clinic on Friday, Saturday, and
17 Sunday nights.

18 Q So, you are a pediatrician? You do not --
19 you're also a pediatric pathologist?

20 A That is correct.

21 Q And you have board certification in pediatric
22 heme oncology?

23 A "Heme" stands for hematology. Specialist in
24 blood disorders and issues related to blood and
25 coagulation.

1 Q Now, not working for -- some people say, well,
2 if you work for -- if you're a pathologist for a
3 governmental entity, say, you're a pathologist for SWIFS
4 or Dallas County Medical Examiner, then you are paid --
5 are you paid by that county if you work, say, for Dallas
6 County Medical Examiner or Galveston Medical Examiner,
7 right?

8 A That would be correct, yes.

9 Q You are a private pathologist?

10 A That is correct.

11 Q So you are not paid by a governmental entity
12 at all?

13 A That is correct.

14 Q We called you and asked you to -- how many
15 people -- in looking at five board certifications, do
16 you know how many physicians in the United States have
17 five board certifications?

18 A No, sir, I do not.

19 Q Is that -- I'm not asking you to toot your own
20 horn, but is that a lot for a physician to have five
21 board certifications?

22 A Well, I guess it is. In my case is because I
23 could not ever figure out what I wanted to do. That's
24 still the case.

25 Q Kind of what you want to be -- Mrs. Sikes

1 saying, kind of what you want to be when you grow up?

2 A Yes. I'm waiting to grow up and that's
3 important.

4 Q What is the difference when you do forensic
5 pathology or do autopsies, you focus on children?

6 A Okay. Now, I'm not a forensic pathologist --
7 and when you use the term "forensics", you're talking
8 about the science related to evaluating death primarily
9 from nonnatural processes, and that's where forensics
10 come in.

11 This is where pediatrics and pediatric
12 pathology overlaps with forensic science, and that is in
13 the area of child abuse and nonnatural child death.

14 Q Do you do autopsies in children to determine
15 if it is a homicide when you conduct an autopsy? Are
16 you looking to see if it is a natural death and
17 undetermined death or a homicide?

18 A This is one of the, to me, interesting
19 misconceptions about the practice of the hospital based
20 pathology versus medical examiner, office based
21 pathology.

22 Q We talked about that. Explain that to the
23 jury?

24 A Hospital based pathology is really focused on
25 understanding disease and disease process and why

1 children die. And it's very important to realize that
2 the vast, vast majority of children's death are due to
3 natural disease processes. It's only a small proportion
4 that's due to nonnatural events.

5 By statute in every state the investigation of
6 nonnatural death is the responsibility of a coroner or a
7 medical examiner system, and in that sense, forensic
8 pathologists have that ultimate responsibility.

9 However, because a lot of children's death
10 that are natural are not known whether they're natural
11 or nonnatural until an investigation takes place, you
12 have this overlap of pediatric pathology looking at some
13 death that fall into the category of suspected natural
14 that can turn out to be nonnatural, and then you have
15 the forensic system looking at deaths that are suspect
16 possibly as being nonnatural, but turn out to be
17 natural.

18 And the ideal situation is where you have
19 active interaction between folks with, in a sense,
20 natural expertise, natural disease and death expertise
21 and nonnatural disease expertise, and that's where child
22 abuse comes in.

23 And both in my -- you didn't ask about my
24 training areas where I worked -- but I was at University
25 of Chicago hospitals for 13 years, Denver Children's

1 Hospital for 14 years, and I've been working at the
2 El Paso Community for about 18 years. In my stint at
3 both in Chicago and Denver, especially in El Paso,
4 intermittently, I've been functioning in a collaborative
5 role and actually at times been given the title of
6 Deputy Medical Examiner -- I don't have that now -- but
7 I have functioned in that role to overlap with this area
8 of when you have a child death, is that death due to
9 natural causes or nonnatural events.

10 And so, it's a situation where this
11 interactive process becomes very important to be able to
12 come up with a proper conclusion about what has
13 happened.

14 Q And so where a forensic pathologist is
15 focusing on manner and death and cause of death, trying
16 to determine those things, are you looking at natural
17 versus nonnatural events that result in death?

18 A Well -- and trying to understand disease
19 processes, because that's the major focus of natural
20 death is what has occurred intrinsic to that child that
21 has brought about death.

22 Again, the one area where it crosses this
23 boundary is in child abuse, and that's where events from
24 caretakers and environmental circumstances provide an
25 explanation for a death, which is not explained by

1 natural means.

2 Q So if you have a child that has died from a
3 nonnatural death, then the historical information on
4 functionality, what the child was doing and not doing
5 then becomes very important?

6 A That's critical, and in general in pediatrics,
7 that's what the pediatrician deals with. The two best
8 indicators that a child is doing okay is, is the child
9 growing appropriately and is the child functioning
10 appropriately, growth and function, and we talk about
11 function in terms of developmental stages. So that a
12 child's functioning at 3 months of age is different than
13 at 3 years of age, different than at 13 years of age,
14 and knowing those differences and functional capability
15 is an important aspect of determining that a child is
16 doing okay.

17 So it's not just the objective growth
18 parameters but it's as importantly the subjective things
19 about behavior and responsiveness and milestones of
20 developmental achievement.

21 Q Let me go back to kind of before I get to the
22 book that you contributed to. At the University of
23 Chicago, the Denver Children's Hospital and where you
24 work in El Paso, was your primary focus then, children
25 and the deaths of children?

1 A My primary focus has always been around
2 children. Death of children has, as a particular issue,
3 I started getting involved in Chicago, but really when I
4 went to Denver, I got involved in a big way, and I was
5 part of an organization called the American Academy of
6 Pediatrics and based on my own background, I was very
7 interested in issues related to Native American children
8 care.

9 And the academy established a committee to be
10 as a resource for the Indian Health Service in Native
11 American community on the health of children and that
12 committee look at why children die on reservations, and
13 a model was established about how to review deaths of
14 children on reservations.

15 When I went to Colorado, I helped Colorado to
16 set up systematic state wide process of investigating
17 the deaths of all children, so that deaths were not just
18 said, oh, this child died. It must be SIDS or it must
19 be some disease and have no investigation.

20 And what became clear from the Native American
21 experience is that unless you do an appropriate
22 investigation, you won't come to an appropriate
23 conclusion about why children are dying.

24 So Colorado was one of the first states with
25 my being involved at the beginning in helping set this

1 up to do systematic death review.

2 When I came to Texas, in 1993, I helped Texas
3 do the same thing, and we now have in Texas and I
4 contributed to this right from the beginning, a
5 systematic statewide death review where each regional
6 area has its own committee of collaborative experts from
7 child advocacy, from law enforcement, pathology,
8 pediatrics, specialist in child diseases and child abuse
9 information to review all of the deaths in El Paso.

10 We have about 150 children's death each year
11 and each one is reviewed by our committee, and I
12 actively participate in that to make sure that these
13 deaths are understood, because children are not expected
14 to die.

15 And when they do, you have to have a good
16 reason to say why this child is dead at that point in
17 time and in its life.

18 Q And that's why when you're talking about
19 children, are not -- like you said, are not supposed to
20 die.

21 So the investigation to get the proper
22 conclusion as to why they did is then critical?

23 A Absolutely right.

24 Q How many autopsies have you conducted, would
25 you say on children?

1 A Well, I don't specifically keep track of that,
2 but over a thousand, and many hundreds over a thousand.

3 Q Of just children?

4 A Of just children. I do, do adult autopsies
5 but obviously my primary interest and involvement is in
6 children's autopsies.

7 Q The difference when you're conducting or when
8 you're looking for conducting an autopsy on a child, you
9 are looking for why this child died?

10 A That is correct.

11 Q Right?

12 A But not in the sense of what forensics is
13 doing to make that determination is it natural or
14 nonnatural in the sense primarily that in the context
15 most of those deaths as I mentioned are natural deaths
16 and in trying to learn what is it about the natural
17 death of this child that could have been prevented and
18 help other children.

19 And that becomes very important, because if
20 you don't expect children to die, and they're dying and
21 you don't understand why, you need to investigate that,
22 because there are other children that may potentially be
23 at risk from whatever disease process or if it is
24 nonnatural from whatever environmental or inflicted
25 events that have brought about the death.

1 Q When you're looking at the difference between
2 a forensic pathologist and you, as a pediatric
3 pathologist, you're looking at the same injuries.
4 You're looking at them from trying to explain this event
5 that has occurred and whether it's natural or nonnatural
6 and ultimately what caused the death; is that a fair --
7 I'm trying to follow you on that?

8 A Right. We use the word "injury". And all
9 children get injuries. And it's important to understand
10 the context of the injury and when you look at a child
11 who is dead. It then becomes important to understand,
12 is this a child who is dead with an injury or dead from
13 an injury and just from that simple concept right there.
14 If it's death with an injury, the death is still is
15 going to be due to some natural cause.

16 If it's a death from an injury, then it's
17 going to be a nonnatural event and the three basic
18 categories of nonnatural circumstances, not natural
19 category of death are homicides, suicide, and accident.
20 And determining what that is, requires a very careful
21 investigation that is not done by the pathologist, but
22 it's done by the people who are trained; law
23 enforcement, Child Protective Services, the people who
24 are trained to go to scenes, understand context, do an
25 investigation that puts the medical findings, which are

1 merely autopsy findings or medical findings in the
2 context of what the environment has, what the story has
3 about where that child was, what happened to that child
4 at different points in time and so a determination of
5 ultimately a manner of death -- in other words, natural
6 or nonnatural. If nonnatural accident homicide,
7 suicide, and of course one doesn't want to use suicide
8 unless you're at an age and developmental state
9 appropriate to that being a possibility and certainly
10 teen-agers, that is a possibility.

11 But the idea of being that unless you have
12 that overall investigation, again, by law enforcement
13 and the nonmedical aspect of the investigation, you
14 cannot make a proper manner determination.

15 Q Okay. So even with the forensic pathologists,
16 that historical information on functionality should be
17 important to them?

18 A Yes. Functionality is a piece of that,
19 because it's more than just in this case in that context
20 functionality, it's the narrative. It's the physical
21 environment. It's things about where the child was, who
22 was with the child, what's reported about what the child
23 was doing. What was happening in the environment.

24 So if you have a child that has injuries and
25 you find out that that child was in a car crash, and the

1 car crash may well account for the injuries, and so you
2 can look at a child who has multiple bruises and
3 internal bleeding and stuff, and all of a sudden getting
4 that information that the child was in a significant car
5 crash with features of the car crash appropriate for
6 explaining those injuries, that makes sense.

7 And then you may or may not put it in a
8 category of accident depending on how that car crash
9 occurred.

10 But if you have a child that has similar
11 injuries, but you have no story of a car crash or a fall
12 or falling into a river and being hit by boulders as
13 you're going down a river, you have a child who has
14 these injuries which are unexplained, and that's with an
15 investigation saying, well, there's no story about why
16 these injuries are there. One of my responsibilities is
17 to make sure that there's not a natural disease that
18 exist in that child that would occur to allow for what
19 looks like injuries to actually be natural disease
20 events.

21 Q Got you.

22 A And excluding that, with no story to account
23 for the injuries, you're left with the unfortunate
24 conclusion that somebody in that environment inflicted
25 something on that child to create those injuries, and

1 again, unfortunately, with child abuse related deaths,
2 that sometimes is a frequent context in which the
3 injuries are placed and that is we've got these
4 injuries.

5 We say that these injuries are related to the
6 death of the child without natural disease accounting
7 for the death, but we have no story that exists to
8 appropriately to accountant for those injuries,
9 therefore, someone in the environment had to have
10 inflicted these injuries to bring about this child's
11 death.

12 Q In this case, were there injuries present on
13 the victim, Kelynn Pinson, that are not explained?

14 A They're not explained by the story, that is
15 correct. And that's a fundamental finding in a child
16 abuse related death or the way I like to put it in an
17 inflicted injury related death. Not necessarily saying
18 that you understand what the actual event was per se,
19 but that you understand that this is a child who has
20 unexplained injuries, unexplained injuries that resulted
21 in the death and, therefore there was something in that
22 environment or something related to the caretaker of the
23 child in that environment that brought about those
24 injuries -- and I'm sorry to ask for this, but could I
25 have some more water? Is that possible?

1 Q When you conduct the autopsies of children, do
2 you categorize their death?

3 A This, again, is one of the differences between
4 a hospital based pediatric pathologist and medical
5 examiner corner system.

6 In Texas it's medical examiner, Justice of the
7 Peace system. We actually don't have corners in Texas,
8 but most states in the United States do.

9 Here in Texas, the big cities have medical
10 examiners and the more rural areas have J.P.s, but in
11 both cases of J.P.s or medical examiners, the
12 responsibility of that system is to determine manner of
13 death. The responsibility of the hospital based
14 pathologist like mine is not to determine manner of
15 death, but only to look at death within the context of
16 natural events.

17 Q Right.

18 MR. THOMPSON: Your Honor, may we
19 approach?

20 (Bench conference:)

21 MR. THOMPSON: Judge, at that point --
22 and I realize -- I understand Mr. Bingham is just laying
23 a predicate, I guess, to get into the questions that
24 he's going to present to this doctor, but at this point,
25 I believe I've heard enough to raise an objection with

1 respect to the testimony that's being offered here,
2 because we're not -- we're plowing new ground and
3 replowing with respect to this witness. This is not
4 rebuttal testimony. This is information, new
5 information that he's presenting through this witness as
6 a part of his case in chief.

7 There's nothing that this witness has
8 said with response to any question asked so far that has
9 anything to do with the testimony that's been presented
10 before the Court in this case. He's not rebutting any
11 opinions. He's not rebutting any evidence offered.
12 We're talking about him examining bodies for the
13 purposes of determining disease.

14 THE COURT: I understand all of that. He
15 hasn't got down to asking -- I mean, I don't know. I'll
16 overrule your objection at this point. He hasn't got
17 down to asking him what his opinions are to review the
18 case and what his opinions are. He's just going
19 through --

20 MR. THOMPSON: Well, then I guess I
21 should request permission from the Court to take this
22 witness on voir dire outside the presence of jury,
23 because if -- the point is this. Once -- the problem is
24 that once the questions have been asked and the
25 responses have been received, even if I object to them,

1 the jury has heard them, and if it's not rebuttal
2 evidence, it should be inadmissible at this phase of the
3 trial.

4 THE COURT: Mr. Bingham I'm sure --

5 MR. BINGHAM: Here's the thing, Judge,
6 what he's talking about now is the difference between a
7 pediatric pathologist and forensic pathologist then he's
8 going -- he just explained the difference between what
9 he does, then he will get in and rebut the opinions that
10 your expert offered. I'm just letting him explain the
11 difference between pediatric and forensic pathologist.

12 THE COURT: If this is some type of
13 objection to where -- I don't know whether to take this
14 as an objection. Sounds to me like all of these type
15 expert situations, he's laying the groundwork explaining
16 what he does.

17 MR. THOMPSON: Okay. Well, I was making
18 an objection, but I'll reserve my objection.

19 THE COURT: Okay.

20 MR. THOMPSON: And then I'll wait to hear
21 what he has to say. And then I guess the Court, if
22 necessary, can instruct the jury to disregard, if
23 necessary.

24 THE COURT: Well, I can, if necessary.

25 (End of bench conference.)

1 THE COURT: All right. Go ahead,
2 Mr. Bingham.

3 MR. BINGHAM: Thank you.

4 Q (By Mr. Bingham) Have you contributed to a
5 book on child abuse?

6 A Yes, sir.

7 Q This book, Child Abuse Medical Diagnosis and
8 Management?

9 A Yes, sir.

10 Q And in this there's a -- talks -- there's a
11 Chapter 19 Pathology of Fatal Abuse?

12 A That's correct.

13 Q Robert H. Kirschner and Harry Wilson?

14 A Yes, I'm the second -- Bob Kirschner is a
15 forensic pathologist who is based in Chicago. He and I
16 knew each other when I was at the University of Chicago
17 in medical school. He went onto become the Deputy
18 Medical Examiner for the City of Chicago. He died a few
19 years ago of liver cancer. He and I worked together on
20 many cases and many investigative issues.

21 Q And one of those is determinations of manner
22 of death as part of this Chapter 19?

23 A That is correct.

24 Q In there you have a table that says, table
25 19.6 that says, sudden death in infants and children

1 determinations of manner --

2 MR. THOMPSON: Your Honor, we're going to
3 object to counsel reading from a document that's not
4 introduced into evidence.

5 MR. BINGHAM: That's okay.

6 THE COURT: All right. That's fine.

7 Q (By Mr. Bingham) Let me show you State's
8 Exhibit Number 214, this a copy of an article that
9 you -- of that one page of this article right here that
10 deals with the importance of historical information as
11 to the functionality of a child when looking at
12 determinations into the manner of death and looking at
13 whether an unexplained death has a natural explanation?

14 A Yes. You said it in a little different way
15 than I would, but it's a chart that shows the importance
16 of context.

17 In other words, there are findings and then
18 there are context for that findings and then the
19 conclusions that you make has to be on what is the
20 context.

21 And so this chart has the autopsy, meaning
22 what the findings are from the autopsy. The
23 investigation, meaning what is the context in which
24 those findings are present, and then the manner of death
25 which is what is assigned and that's a forensic concept

1 of manner of death. And I've already made reference to
2 this whether it's natural or nonnatural, and if it's
3 nonnatural, is it homicide, suicide, or accident.

4 Q And we'll talk about that in just a little bit
5 more in just a minute. I'm going to give this book back
6 to you for just a second and take this from you and,
7 we'll come right back to it.

8 Did you have an occasion to do -- we
9 retained -- we didn't retain you. We asked you to
10 become involved in this case -- because we haven't paid
11 you anything -- back in July, '09 and asked you to
12 consult on this case in July of '09?

13 A That is correct.

14 Q You went down to Southwest Institute of
15 Forensic Science or the Dallas County Medical Examiner's
16 Office, I believe, around September 16th and actually
17 viewed slides in the case of Kelynn Pinson?

18 A Right. That's the office where the body of
19 this two-and-a-half year old boy was taken for autopsy
20 and that's where the medical aspects of investigation
21 occurred.

22 Q And did you travel down there and look at
23 those slides?

24 A The slides and the file that they had the
25 complete file and went through the paperwork and the

1 reports.

2 Q Okay. Let's talk a little bit about -- let me
3 first -- do you disagree with the findings that this is
4 a homicide?

5 A No, I do not.

6 Q You believe it is a homicide?

7 A Yes, I do.

8 Q Do you believe that the injuries to Kelynn
9 Pinson were intentionally inflicted?

10 A Well, you get to a word there that I don't get
11 involved in. I believe that the injuries were inflicted
12 by a person, another human being on this child. I
13 personally don't get into the concept of intent.

14 Q Got you.

15 A But homicide, as a forensic concept, doesn't
16 deal with intent. Intent is what is dealt with in a
17 court of law. Homicide just means in a medical
18 definition is what man does to man by omission or
19 commission to bring about death. And it says nothing
20 about intent, and this is why the medical certification
21 of homicide is not the same thing as saying for
22 instance, murder. It's a different type of
23 categorization.

24 Q Got you.

25 So that's not something you personally get

1 into?

2 A Well, no, no, except I review a lot of cases
3 like that.

4 Q Okay. In looking at this file, did you make
5 conclusions as to whether Kelynn Pinson was a battered
6 child?

7 A Yes, I did make a conclusion regarding that.

8 Q And what is your conclusion?

9 A That this two-and-a-half year old boy indeed
10 based on the findings is what would be categorized in
11 pediatric child abuse context as a battered child, and
12 that has a specific definition that was actually
13 developed by a pediatrician that I knew fairly well. He
14 was from Denver, called C. Henry Kemp and he coined the
15 term in 1961 "battered child", for exactly this type of
16 situation.

17 Q Do you believe that he has -- I believe you
18 mentioned when I talked to you at one point a current
19 multi-focal injury?

20 A Yes. Well, concurrent.

21 Q Concurrent.

22 A Multi-focal injury, but also with evidence of
23 past injury.

24 (Reported by D. Keith Johnson, CSR:)

25 Q Okay. And why is that significant to you, the

1 evidence of past injury?

2 A Well, that -- that battering was not just at
3 one point in time, but there is -- this child lived in
4 the context -- something in his environment, meaning
5 some person in his environment, he lived in the context
6 of having past unexplained injuries and then concurrent,
7 recent unexplained injuries that brought about his
8 death.

9 Q Let me show you a couple of --

10 MR. BINGHAM: May I approach the
11 evidence, Judge?

12 THE COURT: Yes, you may.

13 Q (By Mr. Bingham) Do you disagree that Kelynn
14 Pinson received multiple -- or -- that he had abdominal
15 trauma? Do you think that Kelynn Pinson, when he died,
16 had abdominal trauma?

17 A This little boy had evidence of multiple
18 abdominal blows, and it is most likely from a
19 pathophysiologic point of view that the abdominal trauma
20 to this point brought about his death. In other words,
21 the findings are such that not only did he have fresh
22 abdominal trauma and multiple sites of abdominal trauma,
23 but that abdominal trauma was the precipitating cause
24 for him to be dead.

25 Q Is it significant to you -- you reviewed the

1 photos of Kelynn Pinson, have you not, the autopsy
2 photos?

3 A Yes, sir.

4 Q Is it significant to you that he had multiple
5 bruises to his head, clavicle, back, abdomen, his arms
6 and hands, is the fact that they're all over his body
7 significant to you?

8 A Yes. That's significant for two reasons. One
9 is if there is not an underlying medical reason for
10 having multiple bruises -- and there are disease
11 conditions that can result in multiple bruises. But if
12 there is not an underlying medical reason for multiple
13 bruises, then that means there's been multiple sites of
14 inflicted trauma that have created those bruises.

15 Now, not every bruise on every child is due to
16 inflicted trauma. I mentioned earlier that children get
17 injuries and children get bruises. And one of the
18 things that pediatrics focuses on, the discipline is
19 trying to recognize what is an appropriate injury
20 developmentally for a child versus inappropriate
21 injuries.

22 And, for instance, if you've got a bruise to
23 the leg of a one-month-old baby, that's not an
24 appropriate injury. But a bruise to the leg of a
25 one-month-old toddler is an appropriate injury (sic).

1 And so the context --

2 Q A one-month-old infant or one-month-old
3 toddler?

4 A Sorry. A one-month-old infant should not have
5 a bruise on the leg -- a one-year-old -- sorry -- a
6 one-year-old toddler having a bruise on the leg, that's
7 an appropriate finding, because toddlers do that. They
8 run into things and get bruises on their legs. And it's
9 that developmental context that becomes important.

10 But no two-and-a-half -- a
11 two-and-a-half-year-old will have bruises, but no
12 two-and-a-half-year-old should have multiple bruises in
13 multiple sites that are contemporaneous and significant
14 internal injury in this case on the abdomen related to
15 bruises on the belly. And so that changes these from
16 being developmentally appropriate bruising to inflicted
17 bruising bringing about death, and that's the difference
18 between a homicide or a nonhomicide death.

19 MR. BINGHAM: May I approach the
20 evidence?

21 THE COURT: Yes, you may.

22 Q (By Mr. Bingham) Let me show you -- let's
23 start right here with the body of Kelynn Pinson. You've
24 seen that photograph before, have you not?

25 A Yes, sir, I have.

1 THE COURT: Mr. Bingham --

2 A Yes, sir, I have.

3 THE COURT: -- we're going to need to get
4 the microphone. If you could, move that over where --

5 Q (By Mr. Bingham) I'm going to scoot -- I'm
6 going to be turning you this way to look at the
7 photographs.

8 Let me show you two more photographs that you
9 recognize as coming -- you've seen these photographs
10 before, have you not?

11 A Yes, sir.

12 Q You know that these are photographs of Kelynn
13 Pinson taken at Dallas County Southwestern Institute of
14 Forensic Science, the medical examiner's office?

15 A Yes, sir.

16 Q Let me --

17 MR. BINGHAM: I'm going to tender these
18 to defense.

19 (Counsel confer.)

20 MR. BINGHAM: We'd offer 213 and 214.

21 MR. THOMPSON: No objection.

22 THE COURT: State's Exhibits 213 and 214
23 are admitted into evidence.

24 MR. BINGHAM: Wait a minute. I mismarked
25 it, Judge. I already had a 214. Let me make these

1 pictures 213 and 215.

2 THE COURT: 213 and 215, Mr. Thompson,
3 you don't object?

4 MR. THOMPSON: No objections.

5 THE COURT: 213, 215 are admitted into
6 evidence with no objection.

7 MR. BINGHAM: One of these I've got to
8 show the -- can the witness step down, if I hand him the
9 microphone?

10 THE COURT: Sure. If you would give him
11 the microphone that he could talk into it up in front of
12 the jury.

13 Q (By Mr. Bingham) One of the things that I want
14 to --

15 THE COURT: You may step -- wherever you
16 need to go. You can use the pointer.

17 Q (By Mr. Bingham) Sure. Because I want to
18 address you to this area -- see that line right there,
19 that discoloration -- not the red here, not these little
20 red, but this line right here (indicating)?

21 A Sir, that's more than a line.

22 THE COURT: Doctor, I'm sorry to
23 interrupt you. What I'm going to need you to do -- I
24 know you've only got two hands, but if you would hold
25 that microphone in one of them, and if you're going to

1 point, use the pointer in the other.

2 THE WITNESS: I think I can do it seated.

3 THE COURT: You're fine to step up there.

4 Just need you to take the microphone with you. I need
5 to be sure the court reporters can hear you.

6 A What -- what you are indicating here is an
7 area of discoloration.

8 Q (By Mr. Bingham) Right.

9 A And this is discolorations that has kind of a
10 purplish hue. This is -- I mean, this is different from
11 these other bruise sites, which are red and have a fresh
12 appearance. I mean, dating of bruises is somewhat of a
13 soft science, not a hard science, because what a bruise
14 is, is blood that has leaked out of the blood vascular
15 system into the tissues.

16 And when the blood is in the tissues, it
17 creates an appearance on the outside, based on how long
18 it's been in the tissues, how much is in the tissue, and
19 what the tissue consists of and how deep it is. So a
20 recent bruise in different parts of the body can look
21 different, if there's different amount of blood, if it's
22 at a different level, and whether it's in skin, or skin
23 and fat, or fat, or fat and muscle. It makes a big
24 difference in how it's going to appear.

25 These red bruises are bruises that by their

1 appearance look fresh.

2 This discoloration here is kind of a band --
3 not a line, but a band of discoloration, and this is a
4 common artifact that one sees with bodies that have been
5 cooled where the skin is against the edge of the liver.
6 And this is actually a liver discoloration artifact.

7 Q It's not a bruise?

8 A The only way you can know for sure whether
9 it's not a bruise is when you incise this and you see
10 whether or not there's blood there.

11 Q So if the pathologist, Dr. Quinton, reflected
12 that skin and he says he saw no bruise and there was
13 nothing under the reflection, would that be a bruise?

14 A No, then that is not a bruise. This is what I
15 just call as the -- the discoloration from death of the
16 liver underneath. The liver is a -- I mean, everybody
17 knows what liver looks like. It's kind of a dark red,
18 brown organ. And it gets darker with death, and it has
19 a lot of blood in it.

20 And you actually see the skin -- even with
21 some pigmentation, the skin is still a translucent
22 tissue, and you can see underneath of it, if you have
23 a -- a dark brown organ underlying the skin. And the
24 edge of the liver is below the -- the costal margin, rib
25 margin, you see this -- it's a common discoloration that

1 one sees at death that has nothing to do with bruising.

2 Q So what you're seeing on that line right
3 there, on Kelynn Pinson, you've seen before, it's very
4 common?

5 A It's very common. And, in fact, it's -- it's
6 an artifact of refrigeration and passage of time.

7 Q Which he would be, when these pictures were
8 taken -- the autopsy, you know was conducted June 2nd at
9 7:00 a.m., so he has been refrigerated?

10 A Right. Because the events that occurred led
11 to his death on --

12 MR. THOMPSON: Your Honor, is it the
13 testimony of the witness or Mr. Bingham's statement that
14 the body had been refrigerated?

15 THE COURT: I don't know. Is that an
16 objection?

17 MR. THOMPSON: Yes. We're objecting to
18 the question being leading and suggestive.

19 THE COURT: I'll sustain the objection
20 and ask Mr. Bingham to rephrase the question.

21 Q (By Mr. Bingham) Well, did -- when bodies are
22 sent to medical examiners' offices, do the medical
23 examiners receive the body and just leave them sitting
24 out, or do they refrigerate them before the autopsy is
25 conducted?

1 A Right. I mean standard practice, of course,
2 is refrigeration.

3 Now, there's always issues of transport time
4 and -- the whole basis for refrigeration -- and again,
5 this is something that we all have common experience
6 at -- and that is -- it's like buying meat in the
7 supermarket, that tissues deteriorate more rapidly at
8 room temperature than they do at refrigerated
9 temperature. But even at refrigerated temperature,
10 there are artifactual deterioration changes that occur.

11 And in this case, this is one of those, in a
12 sense, artifactual discoloration things that occurs,
13 because of the underlying liver.

14 But to -- your question, to validate that it's
15 not a bruise, the person who incised -- and the incision
16 that's done for the autopsy at this level on this
17 child's torso is a midline incision that's longitudinal
18 with the body. And when you do that incision, you can
19 see blood that's leaked out of the blood vascular system
20 or not. And so the -- the prosector, the person who did
21 the autopsy, makes that determination in that this
22 discoloration is not due to a bruise.

23 Q Right.

24 MR. BINGHAM: May I approach again,
25 Judge?

1 THE COURT: Yes.

2 Q (By Mr. Bingham) And in State's Exhibit 215,
3 do you see that same discoloration due to the cooling
4 and the liver right here, right?

5 A Right. And it's the color of the liver being
6 seen through the skin.

7 Q Okay. And, again, this is -- this is very
8 common?

9 A It's common and -- and the longer time passes,
10 the more that becomes prominent.

11 Q Let me show you -- let me show you State's
12 Exhibit 115. What are these lines right here in the --
13 what is this right here, that I'm -- what is that
14 called?

15 A Okay. First of all, what we're looking at is
16 the opened torso of this dead child --

17 Q Let me get you to talk --

18 A -- and the -- and the open body. And the head
19 is up in this direction, and this is -- these are the
20 legs on either side here. And there's been a midline
21 incision that's been made here.

22 Here we have heart. This is the chest cavity.
23 The breastplate has been removed so you actually see
24 where ribs have been cut to remove the breastplate and
25 you're seeing the shadow -- the outline of the heart.

1 This is the abdominal cavity. These are
2 dilated intestines. And this is what's known as
3 mesentery with fresh-appearing dark blood in the
4 mesentery.

5 What you were pointing out are dilated
6 intestines. Now, these -- this is not the way the
7 intestines were in life on this child. But one of the
8 things that happens is that because of the bacterial
9 flora that live in our intestines, when we die, gas is
10 formed and the intestines expand. And so what we're
11 seeing is dilated loops of bowel, artifactually dilated
12 as a postmortem change.

13 What you're seeing here is the normal --
14 they're called stria -- the normal lines of fold and
15 expansion of the intestine, which are throughout the
16 intestine, and they're outlined, because there's kind
17 of -- kind of some bloody fluid that's gotten in there.

18 These, to me, are normal appearing intestines
19 in a postmortem effect. But this linearity -- this
20 circumferential, meaning around, linearity, is not a
21 sign of disease or abnormality. It's just the -- the
22 usual folds being accentuated by loose blood and fluid
23 that is present in the abdomen.

24 This child has significant hemorrhage into the
25 mesentery, which are the supporting connective tissue of

1 the intestines, and that hemorrhage and the blood that
2 is then free in the abdomen -- you can see that there's
3 some pools of blood in here. That will act kind of like
4 as a shading effect to any changes in the smooth contour
5 of the bowel.

6 These are normal lines of the bowel where
7 there's a little bit of indentation, and so there's
8 blood from the surface. Not because of bleeding -- not
9 because of bleeding at that site, but just because
10 there's loose blood in the abdomen. It's kind of like
11 coloring so -- the Etch A Sketch thing, where you put
12 sand on something and you have a -- a little
13 discontinuity in the surface, and then you shake it and
14 then the sand rests at places where the discontinuity
15 is. And in this case, the discontinuities are these
16 folds in the surface.

17 But that's not pathology. That's just an
18 artifact of this being a dead child with dilated bowel
19 and these folds.

20 This is the pathology, the blood in the
21 mesentery.

22 Q Are there some deaths that are immediate?
23 There's some trauma that results in immediate death?
24 Can that happen?

25 A Well, absolutely. And immediate death comes

1 from when the heart stops beating or the brain suffers
2 some immediate effect. Absolutely, instantaneous or
3 very, very rapid deaths, yes.

4 Q Was this an instant death?

5 A No, this was not.

6 Q Mesentery -- when you have a mesentery tear,
7 by definition, since it's not immediate, there has to be
8 some range of time. Do you agree?

9 A That is correct. And the reason that you know
10 that there's been a time period is that there has been
11 some accumulation of blood.

12 The blood can only accumulate if the heart is
13 beating. So, you know, if you want to technically
14 define death as cessation of heartbeat, actually more
15 technically the -- we don't have the information
16 regarding this particular child, but more technically is
17 when the brain is no longer functional. In other words,
18 if you have brain death, you can still have heartbeat,
19 but you can be declared dead.

20 Q Right.

21 A But the traditional meaning of death is when
22 the heart stops beating. Well, when the heart stops
23 beating, the blood stops circulating. And when the
24 blood stops circulating, you can no longer bleed. The
25 fact that you have free blood in the abdomen that was

1 measured, that says that this child survived after some
2 major event that led to tearing of vessels; in this
3 case, the vessels in the supporting mesentery and the
4 leaking of blood into the abdominal cavity. So the
5 death was not an instantaneous death.

6 Q Can children live for 24 hours or longer with
7 torn mesenteries?

8 A The answer is yes. There's several factors
9 involved in that. If the death is from blood loss per
10 se, then it's losing a significant volume of blood where
11 you go into shock because of that blood loss.

12 Now, the amount of blood that was in his
13 belly -- and I worked this out -- about five percent of
14 his blood volume. So he did not die from the blood loss
15 in his belly.

16 Now, there are other ways in which blood in
17 the belly can lead to death, and part of that is that
18 the blood doesn't all have to leak out of the vascular
19 system. There's a reflexive response that can occur
20 when you have blood in the belly, is that the blood
21 vascular system in the abdomen can distend and blood can
22 pool in the vascular system.

23 So you don't just have to have blood in the
24 belly -- free in the belly, but you can have blood that
25 is pooled, and the word is used -- the splanchnic bed --

1 it just means the intestinal, vascular bed. If those
2 vessels are dilated and the blood is accumulated there
3 and not circulating, then you go into shock because of a
4 lack of adequate blood volume.

5 We do know that he died slowly, because his
6 brain was significantly swollen, and it takes time to
7 get a swollen brain.

8 And just calculating what his brain weight
9 was -- and I take the organs and I put them on a --
10 their weights on a chart, his brain was, by weight, at
11 the size of an eleven-year-old. And remember, he's
12 two-and-a-half years old.

13 Q Right.

14 A And he had accumulated excess fluid in the
15 brain called cerebral edema, and that took time for that
16 to happen. And that does occur when you go into -- when
17 you have a gradual death in a state of prolonged shock.

18 So he was in shock not only from somewhat
19 blood loss in his belly, but more importantly from what
20 would be called the reflexive dilatation of the
21 splanchnic bed. And I don't want to make that sound
22 complicated, but when you --

23 Q No. That --

24 A When you get free blood in your belly, the
25 vessels in the belly dilate and blood gets pooled in the

1 belly and you go into shock. And, of course, going into
2 shock means that you're not giving enough blood supply
3 to your most important organ, and that's the brain.

4 Q Well, if -- if he goes into shock, then is he
5 going to be normal?

6 A No, he'll be unconscious.

7 Q Okay. How long would you -- let me back up
8 before I even go into how long this -- this timeframe of
9 shock may be.

10 Is this -- when you look at mesentery tears,
11 is this a -- this will not be a medical term --

12 THE COURT: Mr. Bingham, I apologize for
13 interrupting you. We're going to take about a
14 10n-minute recess, break for the jury.

15 All rise for the jury.

16 (The jury left the courtroom.)

17 THE COURT: Doctor, you may step down and
18 take a break if you like to.

19 (Bench conference:)

20 THE COURT: I just want to take up the
21 matter that I believe Mr. Thompson started to make or
22 made an objection regarding the book. And I think you
23 withdrew the question. And I just want to -- if I
24 understand it, the doctor is the author -- one of the
25 authors of a book.

1 MR. BINGHAM: Of a chapter in the book.

2 THE COURT: Of a chapter in the book,
3 okay. And I don't remember exactly what Mr. Thompson's
4 exact objection was, but I think you withdrew the
5 question at the time.

6 What was your objection at the time?

7 MR. THOMPSON: He was reading from a
8 book, in other words, that's not in the evidence.

9 THE COURT: He was reading from the book
10 not -- I'm not sure you actually got the objection
11 out --

12 MR. BINGHAM: We're coming back to that.
13 We have a copy of the page -- of what he wrote for him
14 to talk about.

15 THE COURT: Well, I was going to say,
16 because I was just trying to remember Mr. Thompson's
17 objection. If he wrote something and it was published
18 in a book, obviously he could read what he wrote.

19 MR. BINGHAM: It's his own statement.

20 THE COURT: I just didn't want to get --
21 I couldn't remember what Melvin's objection --
22 Mr. Thompson's objection was, and Mr. Bingham withdrew
23 it. I just thought we might try to.

24 (End of bench conference.)

25 (Recess.)

1 THE COURT: We're back on the record in
2 241-1251-08, the State versus Demontrell Miller. The
3 State's counsel and defense counsel are present. The
4 defendant is present before the Court. The witness is
5 back on the witness stand.

6 Go ahead and ask Carleton to bring the
7 jury in.

8 (The jury entered the courtroom.)

9 THE COURT: Be seated, Ladies and
10 Gentlemen. Thank you.

11 Go ahead, Mr. Bingham.

12 MR. BINGHAM: Thank you.

13 Q (By Mr. Bingham) I think you were talking
14 about, Dr. Wilson, if there was enough blood loss, they
15 would go into shock?

16 A That's one way to go into shock. And that's
17 called hypovolemic shock. In other words, you lose
18 blood. There's not enough blood in the vascular system
19 to maintain blood pressure. But there are other ways to
20 go into shock.

21 Q What is the other way?

22 A The other way is where you have a reflexive --
23 there are many ways, but another way, it is where you
24 have a reflexive dilation of the vascular system. So in
25 effect, even though you may have enough blood by

1 quantity, you don't have enough blood by quantity for
2 the vascular system, which has gone into a reflexive
3 expansion. And that happens when there can be pooling
4 of blood within the vessels of the abdomen.

5 Q Can you give us an example of -- when you were
6 talking about children can live for 24 hours, maybe
7 longer, with a mesentery injury or an abdominal
8 injury -- I don't want to put words in your mouth. But
9 a mesentery -- however you can give an example where the
10 jury can understand.

11 A Well, each injury and each child makes a
12 unique situation and unique combination. And
13 different -- different people respond differently to
14 injury.

15 Some people can have minimal blood loss but
16 have a blow or some type of effect that happens that
17 causes the vasculature to expand, and then if there's
18 not enough blood to fill the capacity of the blood
19 system, the heart cannot do its job and you go into a
20 situation of shock. So you can have not enough blood to
21 fill the vascular system by a combination of losing
22 blood outside the vascular system or increase the
23 capacity of the vascular system.

24 And again, the terminology is splanchnic bed
25 vasodilation. And to a much lesser extent -- but this

1 is why people that have -- that faint suddenly from some
2 type of shock to -- some type of mental shock, you might
3 say, a --

4 Q An outside stimulus that --

5 A Well, that -- that causes a reflexive dilation
6 of their splanchnic bed, their abdominal vasculature.
7 And they get pale and they keel over.

8 You know, we -- we call that fainting. Well,
9 the way you treat that is you lie someone down, you
10 elevate their legs, and you get the blood to go back
11 from the splanchnic bed, from the abdominal vasculature,
12 back into the circulation. But those type of reflexive
13 things with injury can occur and they can aggravate the
14 effect of the trauma itself.

15 And just having blood in the belly can be a
16 very irritating thing. Blood is an irritating
17 substance, and the blood itself can cause dilatation.
18 Someone that has had abdominal trauma with bleeding is
19 not going to be normal. I mean, their belly is going to
20 hurt; they're going to have some of these reflexive type
21 things, and they're going to be very -- it's going to be
22 very apparent that they're in distress.

23 Q You obviously did not conduct this autopsy.
24 We all know that.

25 A That is correct, sir.

1 Q As you look at the photographs of the injuries
2 and you -- the documents you've reviewed, including -- I
3 mean, everything you reviewed in the case, is this a --
4 a very -- as far as mesentery injuries go, is this a
5 pretty bad one, if you're able to qualify it?

6 A Well, with some types of blunt -- and this is
7 known as a blunt trauma injury. And one of the things
8 that is a factor in blunt trauma to the belly, is that
9 because the belly is so soft and compressible, in many
10 ways it's hard to injure structures in the belly.
11 Because what happens is, with an event of a blow, the
12 structures actually move aside because there's a lot of
13 freedom of movement. But one of the things that is
14 characteristic of blunt trauma to the belly is the
15 effect along the midline.

16 And the midline here -- this is the lower part
17 of the belly. Here's where the heart is. And so you
18 can draw a line right along this axis, and you can see
19 that this injury is symmetrical in the midline.

20 And the reason the midline concept is
21 important for belly injury is that when you have a blow
22 to the belly, the item in the body that acts like a
23 scissors with the blow is the backbone. And the belly
24 is not a smooth surface in the back. In fact, it has
25 two troughs on either side with a raise in the middle,

1 and that raise in the middle is where the backbone is.

2 And the backbone is rigid and hard.

3 And so what happens with a blow to the belly,
4 the major sites of injury are where you have a sheering,
5 compressive effect between the backbone and the object
6 that's doing the blow.

7 So a fist to the belly in the midline results
8 in this type of tearing and sheering injury, whereas on
9 either side, the injury is -- is much less, because you
10 don't have that compressive, sheering effect.

11 Q And that -- when you talk about a fist, in
12 this case, we can't pinpoint exactly what the object is.
13 You agree with that?

14 A That -- of course, that is correct.

15 Q It's consistent with -- you were using the
16 fist as an example, as something that can cause that
17 kind of compression against a hard object, like the
18 backbone, that can cause that symmetrical midline, that
19 sheering?

20 A That sheering effect, yes.

21 Q And I want to jump back a little bit.
22 I should have asked you this when we were talking about
23 bruising.

24 When you look at bruising to the abdomen, like
25 you see in Kelynn Pinson, those red bruises, is -- why

1 is it so hard to bruise in the abdomen? Because you're
2 talking about that kind of now a little bit.

3 A Right. And I think it may have come up in a
4 prior question. The way in which bruising occurs in
5 skin is by compressing the skin against a hard object.
6 And, again, with the head, with the trunk, with the
7 legs, with the arms, the hard objects are the bones
8 under the skin. So you bump yourself, you compress the
9 soft tissue against the bone, and you get a bruise.

10 But in the belly, except for this issue of the
11 backbone, which goes along this linear axis from top to
12 bottom, there are no real hard objects. And so things
13 can move aside and not sustain the same type of
14 compressive injury as you would get someplace else in
15 the body, except for the midline, where, again, it acts
16 like a scissors effect, a sheering effect, to cause
17 tears.

18 And so what we're seeing, these are -- the
19 abnormalities here are what are known as mesenteric
20 tears. And mesenteric tears, the mesentery is the
21 supporting connective tissue which has blood vessels and
22 the fibrous tissue that holds the intestine in place.
23 These mesenteric tears are what has created the bleeding
24 here.

25 But these not large tears. It's venous

1 bleeding, so it -- it accumulates slowly over time.

2 And, again, it is not the blood that is causing this kid
3 to go down, but it's the -- the trauma itself and then
4 the body's response to trauma, as I described with this
5 pooling effect of blood within the vascular system in
6 the belly, which would then lead to shock.

7 And what shock is, is where there's not enough
8 blood circulating to meet the capacity of the vascular
9 system. So you can either get into that situation by
10 losing blood -- but I mentioned -- this is only about
11 five percent of this kid's blood volume.

12 Q Right.

13 A Or by increasing that capacity, and that
14 reflexive increase in capacity is what led to this
15 child's shock, poor perfusion of the brain, and then
16 ultimately brain swelling.

17 Because when the brain is damaged, the brain
18 only knows one way to respond, and that is that it
19 swells, and that means when the brain swells, you lose
20 consciousness. And this child's brain was very, very
21 swollen.

22 Q Let me hit three areas real quick, and then
23 I'll come back to them.

24 Is this painful?

25 A First of all, the injury itself is painful.

1 In other words, the blow or blows involved. And because
2 of -- because of the external markings, we have
3 footprints -- I don't mean to imply a foot -- but we
4 have prints of sites of impact.

5 So we have evidence of fresh bruising at
6 multiple sites with a belly that has blood and tearing
7 in it. And those injuries -- this is a beating. This
8 is where this child has been multiply struck, not only
9 in the belly, but at other sites. But it's the belly
10 wounds that led to the death.

11 But in terms of pain, the pain is there at the
12 time of the impact. But one of the things that
13 characterizes abdominal trauma and abdominal wounds is
14 that after the impact, the pain can go away. But the
15 effect -- the bleeding effect can persist.

16 And children who have had these types of
17 abdominal bleeding, abdominal trauma with bleeding, can
18 then linger for hours to sometimes even days, depending
19 on what the actual effect was from the impact itself.

20 So the pain may diminish, but the effect will
21 not go away because the child is bleeding, the child is
22 no longer normally functional, and the child, in this
23 case, because of the brain swelling that would result,
24 would not even be conscious.

25 Q How long do you think he -- looking at the

1 size of the brain, the impacts, the injuries, how quick
2 do you think this child would go unconscious?

3 A Well, the impact sites seem to be
4 contemporaneous, meaning that they all have a similar
5 appearance in terms of their freshness. And it looks as
6 if, at least in the event that occurred, there was
7 several blows in a confined period of time.

8 The bleeding itself is not what led to the
9 child's shock, but it's the dilatation and then going
10 into shock.

11 But putting a range on that is a bit
12 difficult, because these things are more accurately
13 determined by functionality than by findings.

14 But what we do know is that the -- there is no
15 new iron deposition, which is about a 24-hour point,
16 that the -- the reactivity of the sites of bleeding
17 is -- is limited in terms of cellular response. So I
18 would put this in a timeframe of less than four hours,
19 but probably on the order of one hour or so, somewhere
20 in that range, that it's fresh --

21 Q You're talking about from point of
22 impact till --

23 A Till the death of the child.

24 Q Less than four hours?

25 A Less than four hours.

1 And the reason there is that we don't have a
2 lot of tissue reactivity to what's going on. Everything
3 is fresh. There's not a lot of -- very little in the
4 way of secondary response. And we certainly don't have
5 iron deposition, except in an area of prior injury. And
6 I made reference to that, too.

7 But this finding is one of recent, not
8 prolonged, a few hours, and this child would have been
9 in a state of unresponsiveness during this time, and the
10 brain swelling goes along with it. The brain swelling
11 is very significant and very severe, and probably what
12 was the terminal event for this child, in a sense, is
13 not the beating itself, but the secondary fact that the
14 brain, when it swells, it shuts down. And then that's
15 what kills the child.

16 MR. BINGHAM: May I approach?

17 THE COURT: Yes, you may.

18 Q (By Mr. Bingham) Let me show you -- these are
19 not offered into evidence. I will show these to you --
20 and I will just hold them up and -- do you recognize
21 what is contained in State's Exhibit 209?

22 A Yes.

23 Q You took -- you took these photos -- or
24 photographs of the slides, the slides taken in Kelynn
25 Pinson's case?

1 A Right. I did that at the medical employer's
2 office in Dallas where I used a camera and the actual
3 slides from the autopsy and took the photographs with a
4 microscope using the autopsy slides with a camera that I
5 had.

6 Q Same -- same true with 210?

7 A Yes.

8 Q 211?

9 A Yes.

10 Q 212?

11 A Yes.

12 Q All right.

13 MR. THOMPSON: Tender these to
14 Mr. Thompson. And these have been provided previously,
15 but --

16 THE COURT: All right.

17 MR. BINGHAM: We offer 209, 210, 211 and
18 212.

19 MR. THOMPSON: May we approach?

20 THE COURT: Yes.

21 (Bench conference:)

22 MR. THOMPSON: And our objection, again,
23 is that this is not rebuttal evidence. This is new
24 evidence that's being introduced in the cases as if it
25 were part of the State's case-in-chief. So we would

1 object on that basis.

2 THE COURT: That is -- that objection is
3 overruled, and 209, 210, 211, 212 are admitted into
4 evidence.

5 (End of bench conference.)

6 THE COURT: All right. State's
7 Exhibits 209, 210, 211 and 212 are admitted into
8 evidence.

9 And you may publish.

10 MR. BINGHAM: Thank you, Judge.

11 Q (By Mr. Bingham) Can I start off with 209?

12 A Okay.

13 Q Where do you want to start in, because these
14 slides -- I might as well be looking at Swahili.

15 THE COURT: Well, watch the --

16 Q (By Mr. Bingham) These mean something to you,
17 so you tell me.

18 THE COURT: Pass the microphone to the
19 witness, Mr. Bingham.

20 Q (By Mr. Bingham) Let me just get this one.

21 You might want to hold this, and we can spin
22 around in the chair and -- might be easier.

23 Is this easier? Is this okay to start with?

24 Okay. Start with that one. Okay. We're
25 going to start -- I'm going to start with State's

1 Exhibit 212. And, specifically, when you're looking at
2 the timeframe from impact -- the impact to Kelynn Pinson
3 that caused these injuries that resulted in his death,
4 looking from the time of impact until death, why is 212
5 significant to you? What is it and why is it
6 significant?

7 A Okay.

8 Q Do you have a pointer?

9 A Yes.

10 Q Okay.

11 A This is a photograph of a slide of rib, and
12 the rib had an old fracture and evidence of recent
13 hemorrhage at an old fracture site.

14 The reason that it was -- of an old fracture
15 is that there is reactivity on the surface of the rib
16 and there is reactivity regarding fibrous tissue at the
17 site where the rib is separated. This is actually a
18 fracture. This is bone. And bone consists of here of
19 bony spicules and then the loose tissue within the
20 spaces of the bone. And that loose tissue has been
21 replaced by fibrous reactivity.

22 So this is a rib that has evidence of what's
23 known as a healing callus. The word for callus -- the
24 word "callus" means scar, but a scar in bone rather than
25 a scar in soft tissue.

1 An increase of the fibrous tissue on the
2 surface and reactivity of fibrous tissue within the bone
3 and a fracture site, which is an older site
4 (indicating).

5 What has happened to this bone -- and I think
6 it's the next picture --

7 Q Okay.

8 MR. BINGHAM: May I continue to approach?

9 THE COURT: Yes.

10 Q (By Mr. Bingham) Let me -- let me show you
11 State's Exhibit 211.

12 A And what has happened to this bone -- and this
13 is a higher power at this old fracture site -- is that
14 it -- the callus is the body's attempt to heal a rib
15 fracture that's been there for a week or two weeks, but
16 at the same time, there's now fresh blood.

17 Q Okay. Point -- put that red dot on fresh
18 blood.

19 A These are fresh red blood cells.

20 Q Okay.

21 A They're the cells that carry oxygen. And so
22 this old fracture site has had a new bleed with it. And
23 so that's an old injury with now a new injury
24 superimposed.

25 Now, of course, if you have a fracture of a

1 rib and you're subjected to trauma and that rib fracture
2 site is not fully healed, it is going to be a weakened
3 point that is more vulnerable to a second event of
4 trauma.

5 So we have fresh trauma at an old healing --
6 still freshly healing fracture site. And the reason
7 this is important is that it says that this child has
8 had past injury of some sort that caused a broken rib.
9 And this site of this rib is in the posterior aspect of
10 the child's chest.

11 So it -- it's a site that at -- whenever the
12 trauma occurred, the child would have been -- would have
13 screamed and then would have been irritable and then it
14 would have been healing. And there would have been a
15 lump there in the site.

16 Q So it's in the -- that rib is in the left
17 posterior -- back here?

18 A Yes.

19 Q Okay. Like on the back of the left side here?

20 A That's correct, yes.

21 Q What can the fresh blood tell you about
22 timing?

23 A Well, the timing here is a prior injury, a
24 week or two old, and which there is now a fresh injury
25 of just a few hours old. So we have that overlap of old

1 injury, a more vulnerable site, and then a new
2 superimposed injury.

3 Q Okay. And so that red blood tells you that --
4 that the new injury that has brought the oxygen-carrying
5 red blood cells into this -- or blood into this injury,
6 tells you that it was refractured just a few hours?

7 A That's correct.

8 Q Okay. Let's look at this next -- these two.
9 Which one would you want to go to next?

10 Okay. This one. Let me show you State's
11 Exhibit 210. And, again, what is this and why is it
12 significant to you?

13 A Okay. One of the slides that was available at
14 the ME's office from the abdominal tissues from this boy
15 at death was a slide with a special stain for iron. And
16 this is abdominal tissue in the mesentery. In other
17 words, this is a particular site in that mesentery that
18 we were looking at in that gross photo. And, again, the
19 mesentery is the supporting connective tissue of the
20 bowel.

21 And in that mesentery site, with a special
22 stain for iron in this one place in this mesenteric
23 site, there were these very prominent dark blue blobs,
24 which is the iron stain.

25 And this also in itself is evidence of old

1 trauma. Just like the rib fracture showed evidence of
2 healing that was week or so, two weeks old, so also in
3 the mesentery, there's a focus -- an area that was
4 sampled by the pathologist that shows evidence of iron
5 deposition of old blood. Old blood, once it gets
6 processed in the tissue, is turned into iron deposits
7 and it stains dark blue like this on the tissue
8 sections.

9 So the -- this wasn't the case through most of
10 the area that was injured, but it was the case in this
11 one focal area. So just like we have an old injury site
12 to a rib, so we also have in the mesentery an old injury
13 site to a portion of the mesentery.

14 (Reported by Steve R. Awbrey, CSR:)

15 Q And so the mesentery has been injured before?

16 A That's correct. That's what this residual
17 iron says.

18 Q What does that tell you about timing or is
19 that the next slide?

20 A The next slide would help with that.

21 But the timing on this, this degree of iron
22 accumulation and reactivity around it. Again, you're
23 talking days to week.

24 Q From the first injury which -- which injury
25 are we talking about?

1 A The past injury. Days to week of past injury
2 of belly trauma, so what we've got is evidence in his
3 own body that he's had trauma before, trauma to a rib,
4 which there's no record of medical attention for the
5 broken rib and trauma to the belly.

6 There's no evidence of medical attention to an
7 issue of you know being hit in the belly or having some
8 fall impalement with a bike handle bar, no explanation
9 of a past event of injury.

10 Q Let me show you then, as we look at the slides
11 dealing with the mesentery, you looked at other slides
12 as well?

13 A The slides that were available in this case.

14 Q In this case with Kelynn Pinson.

15 Let me show you State's Exhibit Number 209,
16 what's this a slide of?

17 A Now, this is another area of mesenteric blood.
18 These slide corresponds to the area of blood that you
19 were pointing out in that open belly picture of this
20 child.

21 And this is blood now that's free in the
22 soft-tissues, the connective tissues of the mesentery.
23 In this field there's not the presence of iron, but
24 there's the presence of fresh red blood cells.

25 So the point is that just with as it was with

1 the rib, where there was evidence of a past injury and a
2 coexisting recent injury within a few hours, the same is
3 true of the belly. There's evidence of a past injury
4 and then the majority of the belly injury is this recent
5 injury with fresh red blood cells.

6 The issue of fresh red blood cells without
7 iron deposition, is that the red blood cells are
8 normally formed. They're not where they're supposed to
9 be. They're supposed to be in the blood vascular system
10 within vessels. They're normally formed, and there's
11 not the accumulation of iron.

12 Q Well, again, on the page before it's got blue
13 dots on it, and that one has blue dots on it?

14 A I'm sorry about that. These are different
15 stains. The one before, the stain is a special stain
16 for iron. You notice how pale it was. Everything else
17 is pale. This is a standard stain where the blue dots
18 here are the nuclei of white blood cells. And our blood
19 contains both red blood cells and white blood cells, so
20 this is blood that has leaked out into tissues
21 without -- it's only been there a short time. The red
22 cells have not broken down and this location, there's
23 not the presence of iron as a sign that it's been there
24 for a period of time.

25 Q The fact that there's blue dots on both

1 slides, they're not the same blue dots?

2 A The other blue clumps.

3 Q Clumps.

4 A On the other slide were iron deposits.

5 Q Okay.

6 A The blue dots here are the nuclei of white
7 cells.

8 Q So when you look at that photo and you see the
9 presence of red blood cells, then that tells you that
10 there's been an injury to that mesentery of less than
11 four hours?

12 A Right, fresh injury, that's correct.

13 Q Well, what if another doctor said that when he
14 does the microscopical examination that if you have the
15 movement of white blood cells into the gut, that means
16 that the injury is a minimum of 8 hours old?

17 A There's two issues here. First of all, we're
18 not in the gut. We're on the outside of the gut. This
19 is in the connective tissue on the outside of the gut,
20 so that's not what the slides show.

21 This is the supporting tissue. The mesentery
22 is the supporting tissue of the gut. This is not a site
23 in the gut at all. And then when you bleed, you bleed
24 everything that is in the blood vessel, and that's a
25 mixture of red cells and white cells, so bleeding itself

1 allows for white cells to go into where the blood is
2 accumulating.

3 What he's talking about is the separate
4 migration of red cells -- I'm sorry -- of white cells to
5 an area of injury and migration into an area of injury
6 is different from white cells that are present because
7 of bleeding. So what we're seeing here is what cells
8 that are just part of the blood that has leaked out into
9 the tissue.

10 Q Okay. So when you have white cells that are a
11 part of the blood that has leaked into the tissue, he's
12 got that confused?

13 A Well, I don't know if I would use the term
14 "confusion", but it's being misapplied, because
15 bleeding -- when bleeding occurs, which means that the
16 blood goes out of the blood vascular system, there's not
17 a selective bleeding of just red cells. It's red cells
18 mixed with white cells.

19 Q There's actually an article -- when they talk
20 about that this minimum of 8 hours, even though it's
21 been misapplied, there's actually an article, is there
22 not, when you rely on articles that people rely on
23 within this scientific community, there's an article
24 that talks about this three-hour window, is there not?

25 A Well, right. In fact, you start seeing

1 migration of the white cells within a matter of minutes,
2 can occur, but the white cells respond to the stimulus
3 of injury, but when you start seeing them accumulating
4 in an abnormal fashion, it's a matter of several, a few
5 hours. That's correct.

6 And the work on that was actually done by a
7 man called John Rebuck who was interested in -- I just
8 happen to have his reference here, but he was interested
9 in looking at how white cells respond to injury where
10 they are attracted to a site of injury.

11 That's different from white cells that end up
12 in the tissue because you've been bleeding. So if you
13 bleed and you have white cells there, it's just because
14 they're part of the blood that leaked out of the
15 vascular system, the blood composed of white cells, red
16 blood cells, platelets and liquid.

17 If you have a response to a site of injury,
18 then they migrate there, and so that's the difference
19 between migration and bleeding. Bleeding brings white
20 cells. This is bleeding. Attraction in a few hours
21 allows for white cells to come there.

22 But these sites of bleeding have not been
23 there long enough to really have a secondary reaction.
24 In other words, this blood that's there is fresh, and
25 it's fresh of just a few hours of age.

1 Q You were talking about functionality is
2 important. We've talked about that.

3 A The child's functionality.

4 Q The child's functionality is important?

5 A Yes.

6 Q I know you've not seen State's Exhibit Number
7 199 before, but I'm going to show this to you. It's in
8 evidence, but we have up here Friday, May 30th, '08. We
9 have Saturday, May 31st, '08, and we have Sunday, June
10 1st '08.

11 Then we have certain times on all of these
12 days. The child -- paramedics, I have marked on here,
13 I'll give you these and ask you kind of a question from
14 it.

15 It's in the record that at 12:56, paramedics
16 responded to this location, and they noticed that the
17 victim was cold. He had a bloody stool. He was not
18 responsive. He had no heartbeat, and he never got
19 that -- they never is astolic?

20 A Asystolic, yeah.

21 Q And they try to work on him there. They leave
22 a few minutes later. They arrive at Trinity Mother
23 Frances at 1:12.

24 Dr. Anderson is unable to regain a heartbeat.
25 He's an ER trauma doctor. He's unable to regain a

1 heartbeat. At 1:15 the rectal body temperature is 91.1.

2 Now, let me go back some.

3 9:30 on Friday, May 30th, the testimony is
4 that this picture right here was taken of Kelynn Pinson.
5 I'll show it to you. State's Exhibit Number 10. Okay.

6 Does that look like a child that's had any
7 trauma resulting in the injuries that ultimately
8 culminated in his death?

9 A No, sir, it does not.

10 Q This photograph, to give you a point of
11 reference was taken about right here.

12 At 10:30, the testimony is the child is
13 normal, riding to McDonald's in a car with his dad who
14 is in that photograph right there. Then throughout the
15 rest of the day, he is acting normal, happy. He takes a
16 bath. No one sees any bruising. Nothing to indicate
17 that he's in any trauma at all.

18 At 5:30, he's at the Wal-Mart, and he's hiding
19 from his dad in some clothes.

20 Is this the type activity that you believe
21 would be -- that a child that's in -- that's received a
22 mesentery tear like Kelynn did that how they would act?

23 A No way, sir.

24 Q Okay.

25 At 6:00 -- this is give or take a few

1 minutes -- he's dropped off with his mom, Ceola Pinson.
2 That's where the mother and the defendant lived
3 together. Kelvin Pinson is the father. He's never been
4 married to the mother. They live separately.

5 Saturday, May 31st, starting about 1:00, we're
6 not clear what happens in here. But Saturday at
7 1:00 p.m., the defendant is going to go buy some
8 clothes. They get up. They go get something to eat.
9 They go to eat. They go to restaurant to eat. They
10 then go to a clothing store. They go to a mall. They
11 go to a relative's house. The child, the testimony is,
12 does not eat as much as he usually does.

13 Then they go on -- they drop the child off
14 sometime 5 to 6:00 at a baby-sitter's house. Present at
15 that house are Dakeidra Choice, Chasitie Ford, and
16 Fredrick Suell.

17 We know at that house Fredrick Suell gives the
18 child, he's wanting something to eat. He wants
19 something to eat. He gives him some cereal. There's no
20 milk in it. He hands him some cereal. But the child
21 appears to be normal. He's actually playing ball,
22 throwing the ball around. And during this window of
23 7:15 p.m. to 9:30 to 10:00 p.m., he eats more cereal.
24 He eats some noodles. He actually walks to the mailbox
25 holding hands with an adult. There's like a community

1 mailbox at the apartment complex where there's a bunch
2 of individual mailboxes.

3 He actually gets on a Big Wheel scooter and
4 sits on it and kind of pushes himself, scooting himself
5 along the floor. There's no signs at all to any of
6 these people that he would be in any kind of distress at
7 all.

8 Is there any indication -- I mean, is this the
9 normal activity of a child who would be suffering from
10 these kinds of injuries?

11 Is this something that he would do, scoot
12 around on a Big Wheel, play ball, walk to a mailbox?

13 A Sir, with blood in your belly, with torn
14 mesentery, with trauma that is affecting not only how
15 you feel, but how you can function, he would not want to
16 move. He would certainly not be eating, and if he took
17 in fluids at all, he would be vomiting, and it would be
18 the movement -- any movement that bent him over like
19 being on a bike or agitated his belly, blood, free blood
20 in the belly is a very irritating thing.

21 And this is an experience that women have
22 during ovulation when there's a release of just a small
23 amount of free blood in the belly. That can be a
24 painful thing, because of the blood itself. Blood is an
25 irritating substance for the peritoneal cavity. He

1 would be dysfunctional, in pain and not able to do any
2 of those things.

3 Eating, being an especial stress test affect.
4 He would not be able to eat or hold down food.

5 Q At 11:00, they bathe him. He's kind of dozing
6 off about 9:30 to 10. This is a 2 year old. It's about
7 9:30, 10:00 at night. He starts getting kind of sleepy.
8 He doses off. They wake him up, and give him a bath
9 sometime around 11:00, and he sits in the tub. The
10 person bathing him, Dakeidra Choice, says she does not
11 notice any bruising. He seems to be tired, but normal.

12 She takes him out the bathtub, and he goes
13 back to sleep.

14 Even bathing a child, would that be
15 inconsistent with trauma having occurred at this point?
16 I guess, you could bathe a child in this kind of trauma,
17 but the child would be?

18 A Either in great distress or unresponsive. I
19 mean, so you can, of course, bathe someone who is
20 unresponsive, and the distress would be such that there
21 would be an element of lethargy and poor responsiveness
22 associated with that, but just movement, just pressure
23 on the belly when you have free blood in the belly,
24 causes discomfort.

25 Q Okay.

1 At sometime around June 1st, the mother and
2 the defendant show back up at the apartment. They pick
3 him up around 2 a.m. or 2:30. He's asleep. He's
4 awakened. Seems to be drowsy, but he's been asleep.
5 It's 2:30 a.m. in the morning on Sunday June 1st. On
6 the way home, the child expresses an interest in
7 something to drink. They don't give him -- there's an
8 energy drink in the car. They don't give it to him,
9 because it's an energy drink. He seems to be whining,
10 because he wants something to drink, but appears to be
11 normal. When they get home, he goes and puts himself
12 into bed.

13 He walks from the car to the apartment where
14 they have to walk upstairs -- I mean, let me start with
15 this. Would walking upstairs be a very difficult thing
16 to do with free blood in your abdomen?

17 A Again, free blood in the abdomen in the
18 peritoneal cavity is a very irritating substance and
19 movement of any sort causes great problems.

20 Because of the discomfort involved. I mean,
21 someone that has that, whose not in shock, is going to
22 want to be as still as possible, and walking is not
23 something you're going to want to do.

24 Q So you sure wouldn't be walking and acting
25 normal as a 2 year old?

1 A That is correct, sir.

2 Q The mother even asked him at one point, she
3 hears something, a thump or a knock, and she says, are
4 you okay, Kelynn, and he answers, yes -- I have "mommy",
5 but I think it's actually, "mama" -- yes, mama. About
6 5:15, the mother -- he's still asleep. The mother moves
7 him to the couch, and the mother says he appears to be
8 fine and asleep.

9 9:15, the mother comes home. He's still
10 appears to be asleep, and she stands over him for a few
11 minutes and he looks normal to her.

12 9:15, around that time, is the last time
13 anyone but the defendant sees the victim alive.

14 Now, the defendant says what's in red here.
15 Here's his statements to the police.

16 He says that at 11:30, the victim woke up. He
17 ate a sandwich and maybe some cereal. Knowing that the
18 child at 12:56 is cold, unresponsive, no heartbeat.
19 Would it be consistent that at 11:30, he would actually
20 wake up and eat a sandwich, do you believe?

21 A The period of time from 11:30 to -- what was
22 the time that you said?

23 Q 12:56, the paramedics get there. We know he's
24 dead by 12:56. We don't know how long he's been dead?

25 A That period of time is too short for the issue

1 of heat loss and for the issue of the injury having
2 occurred prior to that. I mean, what you have is that
3 when the child is asleep, you don't know whether the
4 child has been injured or not, but once -- if you have
5 interaction such as feeding interaction or activity,
6 that is not consistent with these injuries that brought
7 about this death.

8 So either the story is wrong, or the injury
9 hasn't occurred yet, and that period of time is not
10 appropriate for the injury having occurred earlier.

11 Q Right. Because we know that he's dead at
12 12:56. That's a given. Do you believe that -- and if
13 he's dead at 12:56, him waking up at 11:30 wanting to
14 eat a sandwich, maybe some cereal is not consistent?

15 A That is -- has to be a false story.

16 Q Okay.

17 A Not the least of which is the body temperature
18 issue. You can't lose that much temperature unless the
19 child was placed in a refrigerator for that period of
20 time to have a core temperature of 91 degrees, I think
21 you said.

22 Q Have you ever heard of vasoconstriction?

23 A Vasoconstriction.

24 Q Vasoconstriction.

25 A Gives you your external temperature being low

1 and that can happen to someone who is alive.

2 But the core temperature, and I understood
3 that this was measured by a rectal thermometer, that's a
4 core temperature measurement, so that's a valid
5 measurement of the body's internal temperature.

6 Q If are you in vasoconstriction?

7 A Yes.

8 Q Is the body trying to preserve heat or expel
9 heat?

10 A Well, it depends on whether it's
11 vasoconstriction from a physiologic response or a
12 pathologic response.

13 Q How about in this case. I don't know which
14 one that would be?

15 A But a physiologic means that your body is
16 responding to like cold outside and so you go into
17 periphery vasoconstriction, because you don't want to
18 lose excess heat to the cold.

19 If it's a pathologic response, then it can
20 associate with injury, both of which allow for a
21 conservation of heat, but with the pathologic response
22 it's not necessarily something that's helpful to your
23 body to be able to cut down on heat loss to the outside.

24 Q So -- knowing that -- taking into account what
25 you just talked about with the vasoconstriction, do you

1 see any way that this child -- let me take it even
2 further.

3 According to the defendant, he says at 12:30
4 the victim, Kelynn Pinson, is enthusiastic to go
5 swimming. He's wanting to go. He seems normal. He's
6 ready to go swimming? He changes his clothes and
7 carries him to the pool. And he gets down to the pool
8 and he puts him in the water and everything is going
9 great until the other child starts to cry.

10 The defendant then leaves Kelynn down at the
11 pool, you know, sometime in this timeframe and goes back
12 upstairs. Let me start here.

13 Do you think it is that the child was alive at
14 12:30 wanting to go swimming with all you've looked at
15 in this case and knowing that he is dead for sure at
16 12:56? Do you think that that's true that he was
17 enthusiastic about going swimming at 12:30?

18 A The rapidity of death for this child has a
19 range and the range can be as short as less than an hour
20 or up to a few hours.

21 But the issue here is that the functionality
22 of this child is not appropriate for an injury having
23 occurred for a few hours beforehand. Can't have an
24 injury like this and still be functional at the time
25 that it's said that this child is functional.

1 If that story is to be believed -- and, again,
2 you can have a compressed process of less than an hour,
3 then the only person who is involved in the care is the
4 defendant as you're describing things.

5 So it's kind of like you can't have it both
6 ways. If the child was preinjured, he's not shown signs
7 of that injury and the findings are not consistent with
8 an injury of over 4 hours, and if he's fully functional
9 up to this point, then he hasn't been injured yet and
10 then the injury is only -- can only take place under the
11 hands of the defendant.

12 It seems to me that the story of his having
13 activity at that point based on the timeframes involved
14 is not a valid story.

15 To me the only explanation is that this is a
16 bogus story to say that the child is in good condition
17 right up to the point where the child ends up going to
18 the pool.

19 That to me does not fit with what the evidence
20 shows. But even if the timeframe is constricted like
21 that, to let's say less than an hour or even a half
22 hour, the only person with the child at that time is the
23 person who would be responsible for these injuries.

24 Q Well, then if -- let me take it even further.

25 At the pool, he says when he comes back, he's

1 gone upstairs, taken the small child upstairs, he comes
2 back. And Kelynn has actually fallen into the pool or
3 climbed into the pool and he is holding onto a ladder
4 kind of like this around the ladder, and he is
5 unresponsive.

6 And the defendant then rushes over, pulls him
7 out, with one impact to the chest, Kelynn then wakes up
8 and says that he's hungry, eat, eat, is what he says.
9 He's hungry.

10 So let me start with that. Does that story
11 seem plausible to you?

12 A The whole story about the child being in the
13 pool does not seem plausible. And then what you're
14 describing does not seem plausible. These injuries can
15 have been there for a few hours. Even if they were
16 there for a short period of time, once the injury
17 occurred, this child would not be normally functional in
18 any stretch of reality.

19 So it's kind of like having, trying to have it
20 both ways. If the injury preexisted, then the child
21 couldn't have done any of these things, and if the
22 injury didn't preexist, then the injury was inflicted at
23 some time during this story, which doesn't make sense to
24 account for the presence of the injury.

25 Q Either way, if he is dead at 12:56, there is

1 no way that he is alive -- first of all, he would not,
2 with what you're saying with his injuries, he would --
3 his symptoms, the way he would be acting, is absolutely
4 inconsistent with wanting to go swimming, number one,
5 right?

6 A Well, any -- if he had these injuries, he
7 would want to protect himself from any movement and any
8 activity. The -- again, remember that the brain
9 swelling shows that he's been in a down condition for a
10 somewhat prolonged period of time. Less than four
11 hours, but still he may have been down for an hour or
12 even two hours.

13 Q Okay. So his brain -- what should it be --
14 how do you measure the weight? Is it pounds, ounces,
15 the weight of a brain?

16 A In grams.

17 Q In grams.

18 What is a normal weight for a 2 year old --
19 what is the normal weight of the brain?

20 A For a 2 year old, it's about 1 kilo, so about
21 a 1000 grams or 1100 grams.

22 Q 1000 to a 1100 grams.

23 What was his?

24 A His was about 1340. Let me see exactly. 1340
25 was the exactly what it was.

1 Q That doesn't sound like a whole lot, only a
2 couple of hundred?

3 A But with the brain that's very significant.
4 It's proportional increase.

5 Q It's only 20 percent?

6 A 20 percent increase in brain weight, that's
7 water in the brain. There's a reason that it increases
8 is because of fluid and fluid is called cerebral edema
9 and when you have any swelling of the brain at all, the
10 brain becomes dysfunctional. Even the small amounts of
11 cerebral edema is bad, and a 20 percent increase is a
12 significant amount of increase.

13 Q So in that -- that alone tells you that there
14 has been a period of downtime, right?

15 A That's right.

16 Q When a person -- what is a stroke? Does that
17 result in swelling of the brain?

18 A A stroke has several meanings, but it's
19 usually when there's been a blood vessel that's ruptured
20 and the blood then has leaked into the brain. The blood
21 itself is an irritant and the brain starts swelling in
22 response to that.

23 But, there's two types of strokes, bleeding
24 strokes and clotting strokes. But the bleeding strokes
25 are the ones that actually can be the worse to manage,

1 because of the difficulty of continued accumulation of
2 blood.

3 Q The swelling of the brain is what they're
4 concerned with there?

5 A Right. You have the initial injury from where
6 the bleeding occurred, but then the secondary injury
7 that makes the damage much worse is the swelling that
8 results from that event. There was no stroke.

9 Q No, I know. I was just looking at -- the
10 swelling of the brain is always a concern, medically?

11 A That is correct.

12 Q In any amount?

13 A That is correct.

14 Q Let's talk a little bit about the defendant in
15 this case says that at some point, 12:30, that the
16 victim has white mucus coming out of his mouth. He says
17 actually at sometime between 12:35 and 12:40, the victim
18 is drinking a soda, does that sound reasonable to you?

19 A If the boy is able to drink and is functional,
20 he has not yet been injured. And what I'm saying here
21 is, you can't have it both ways. Either the boy was
22 injured beforehand and these are results of progression
23 of a problem, or the boy is injured sometime very close
24 to when emergency is called.

25 The evidence is that the boy was -- the

1 medical evidence -- was injured for a period of time, a
2 few hours perhaps at the most, but injured such that his
3 brain swelled significantly, but not injured enough long
4 enough to accumulate a lot of blood in his belly. So
5 the amount of bleeding time was more oozing-type
6 bleeding. It still took time, but it was not a long
7 prolonged period of time.

8 This all comes down to a few hours, less than
9 four hours, just a few hours.

10 Q So from the point of impact until death is
11 four hours or less?

12 A Multiple impacts.

13 Q Multiple impacts is four hours or less, right?

14 A Right.

15 Q So if he's dead at 12:56, you put the window
16 somewhere 9:00 on?

17 A Right, that's correct.

18 Q 9:00 on.

19 So you put the point of multiple impacts that
20 results in his death as occurring at 9:00 a.m. on
21 Sunday, June 1st '08 or later?

22 A But if there's any truth to the stories of his
23 functionality later in the morning, that means he hasn't
24 been injured yet by any means.

25 Q So what you're saying is if the defendant was

1 telling the truth to law enforcement that at 12:30 he
2 wanted to go swimming, then one of two things is
3 happening. The defendant is lying, or he hasn't been
4 injured yet?

5 A Right.

6 Q And based on the fact that he's dead at 12:56,
7 do you believe he would have been injured at 12:30?

8 A With his body temperature and with the degree
9 of brain swelling and with the findings of the
10 compilation of findings here, that doesn't make sense.
11 To me, that's too short a period of time.

12 It may have been an hour before that or
13 something like that, but the story -- either story of
14 him being preinjured or just injured for just injured
15 for just a very short period of time doesn't work.
16 It's -- the truth is probably somewhere in between. One
17 to two hours before he's discovered by medical
18 personnel.

19 Q Now, the defendant never calls 9-1-1. He says
20 in his statement, he's too shocked at what's going on to
21 call 9-1-1, but he does call the mother at Burger King.
22 He calls her at 12:40. He says that the victim is
23 alive. In other words, he still has a heartbeat, but
24 his eyes are rolling back in his head and he's rolling
25 side to side.

1 Before I get to that, let me back you. The
2 white mucus, is it possible that the injuries could have
3 been inflicted, the child could be in trauma and had
4 white mucus coming from his mouth?

5 A Sure.

6 Q If I hit or kick somebody with great force or,
7 say, a child in the stomach with an object, could that
8 cause that child to, when I begin to strike those
9 impacts, to vomit?

10 A Sure.

11 Q Let's talk about the core body temperature --
12 before I get to that.

13 Is it your conclusion then that based on the
14 timing of the defendant's statements that what the
15 defendant is telling law enforcement that at 12:30, he
16 wanted to go swimming. At 12:35 to 12:40, he's drinking
17 a soda. At 12:35 he's holding onto the ladder. He's
18 not responsive, but becomes responsive with an open palm
19 strike, and then the victim says eat, eat, I'm hungry.
20 Do you believe those are true?

21 A No, I do not.

22 Q The 91.1 degree rectal body temperature. Tell
23 me some way, if you can, that he could have a core body
24 temperature of 91.1 if at 12:56 paramedics say he's dead
25 at that point and if he is drinking a soda, say at 12:35

1 or he's enthusiastic to go swimming at 12:30, how -- is
2 there any way that you could think of he could have a
3 rectal body temperature of 91.1 at 1:15?

4 A He's been refrigerated.

5 Q Absent some intervening thing like
6 refrigerating, is there any way vasoconstriction,
7 bleeding into the abdomen, shock, would any of those
8 cause him to have a core body -- a rectal body
9 temperature of 91.1 at 1:15?

10 A That's the whole point of the rectal body
11 temperature. I've already said that the external
12 temperature varies very dramatically, and that can be
13 low and not be a true reading of what his true
14 temperature is.

15 The fact that it's a core rectal temperature
16 says that he's been losing heat for two or three hours
17 at the point that that was done. And, no, he doesn't
18 necessarily have to be dead for two or three hours, but
19 he's been injured and approaching death for that period
20 of time, because he's lost the ability to regulate heat
21 and losing that ability is one of the functions of --
22 that happens with brain trauma.

23 Q Well, if another physician said that a rectal
24 body temperature is not a core temperature -- you don't
25 know Dr. Pustilnik?

1 A No. That's what rectal temperature is, is a
2 core body temperature.

3 Q What is the core of a person?

4 A The -- well, the core means something
5 internal, not on the skin. So you're not measuring it
6 by feeling the skin with some temperature probe. You're
7 getting inside the body cavity somewhere.

8 Q Do you think the rectal body temperature is a
9 valid, a good way to measure core body temperature?

10 A It's kind of the standard way that's it's
11 done.

12 I mean, that's why it's considered a guideline
13 if you want to know truly what someone's temperature is.
14 It's not done very much anymore, because there's so many
15 more convenient ways to do it, but that's what it's
16 purpose is.

17 Q You could stick something into the liver,
18 could you not?

19 A Then you're presuming that a person is dead.
20 I mean, before if you're going to do something like
21 that.

22 Q That's true.

23 Also then you have put an injury into a body
24 that might be looked at for a homicide, which you don't
25 want to do, would you agree?

1 A Right, right.

2 Q Let me show you, do you believe the bruising
3 on Kelynn's body, do you believe this red bruising right
4 here is -- you say it's fresh, and I know you don't like
5 to time bruises, you agree with that?

6 A Yes.

7 Q But do you believe that these injuries that
8 you see on his stomach here and really on State's
9 Exhibit Number 213, it shows the same injuries. It's a
10 different photocopy. Do you believe those are the
11 result of impacts, multiple impacts that caused the
12 injuries to the mesentery?

13 A Yes. You have almost a direct line of force
14 relationship. And as I mentioned before, the injuries
15 to the mesentery are caused by a compressive effect
16 between impact trauma to the surface of the belly and
17 compressing the belly structures with the backbone, and
18 that's what resulted in the tearing, those multiple
19 small tears present in the mesentery and the bleeding
20 associated with that.

21 Q Let me ask you this. If you a have forensic
22 pathologist and you are a pediatric pathologist, who is
23 more qualified to look into the body of Kelynn Pinson
24 and tell what the injuries are and give testimony as to
25 when they would have been inflicted and look at slides?

1 A Well, what forensic pathology is, is the study
2 of nonnatural events. That's what forensic pathology
3 training is. What pediatric pathology is, is the study
4 of kids and understanding how kids' bodies respond to
5 things. My answer to that is that the ideal situation
6 would be a collaborative effort between a forensic and
7 pediatric pathologist to provide answers and incites
8 into those type of questions.

9 Q Is this a complicated case to look at and give
10 testimony on?

11 A Actually, it's not very complicated in the big
12 sense, in that you have child who by history is doing
13 fine, and then he's suddenly and unexpectantly unwell
14 and dead, and you look to -- you find unexplained
15 trauma. So you look to the story of what occurred or
16 did not occur. Was he in a car accident? Did he fall
17 from a building? You don't have that information, so
18 therefore the unexplained trauma had to have been
19 inflicted on him in a relatively short period of time.

20 Before the trauma was inflicted, he was
21 functioning fine, and after the trauma is inflicted, he
22 lingered perhaps for a perhaps a couple of hours, but he
23 died as a result of the inflicted trauma.

24 Q What is the fact that someone let Kelynn die
25 tell you about -- you don't like to comment on whether

1 something is intentional or not, do you?

2 A No. You know, a single blow event, you can
3 have some ideas about regarding maybe a loss of control
4 or some type of even circumstantial accident, but when
5 you have multiple sites of impact, this conveys a higher
6 level of intentionality. It conveys there is --
7 something that has occurred in the environment to this
8 child that has occurred multiply. You can't account for
9 this by any circumstance in the environment other than
10 another person's actions. That means that you have
11 multiple blows, and the more multiple blows, the more
12 you do get into that realm of intentionality.

13 Q Maybe it's me, but, how does common sense play
14 into this thing? Is common sense something that
15 forensic pathologists, pediatric pathologists should
16 always apply -- let me back up. Let me rephrase this
17 question.

18 Does it make sense, common sense-wise that a
19 child would be dead at 12:56 suffering the kind of
20 injuries that Kelynn Pinson suffered and with wanted to
21 go swimming at 12:30, shouldn't doctors look at that and
22 go, heck, that just doesn't make sense?

23 MR. THOMPSON: Your Honor, I'm going to
24 object to the form of the question.

25 MR. BINGHAM: Whether doctors can look at

1 something and tell if it makes sense?

2 THE COURT: Overrule the objection,
3 Mr. Thompson. Let him give his opinion.

4 Q (By Mr. Bingham) Well, I mean, shouldn't
5 doctors be able to look at -- maybe it's me? I'm no
6 doctor. I promise you that. But this looks something
7 like this and go, hmm, let me look at this for a second.
8 If he's dead at 12:56, this doesn't look like the
9 injuries someone would be enduring and wanting to go
10 swimming 26 minutes earlier, can't you just do that
11 medicine -- shouldn't doctors do that? You understand
12 my question?

13 A Of course the answer for a reasonable person
14 is, yes, doctors should do that.

15 I appreciate that the issue here is whether
16 there is a story to account for why this child is dead
17 and a story of a child being in good shape until the
18 last minute prior to his collapsing unexpectantly. It
19 just doesn't make sense. It doesn't make sense with the
20 pathology findings. It doesn't make sense historically
21 but the reason stories like that don't make sense is not
22 because that the injuries are not explained. It's
23 because the story doesn't account for them.

24 And this -- both by timing and by quantity,
25 here the only way to account for the multiple sites of

1 bruising, the degree of injury in the belly and the fact
2 that this child with these injuries would not have been
3 functional is that the stories are bogus. The story
4 that's being given is bogus.

5 Therefore with a bogus story, you to try to
6 piece together things based on other information, and we
7 have a timing window when other people saw this child
8 being fine, and as long as the child is fine, he's not
9 been injured. And once the child is in someone's
10 exclusive care and he has unexplained injuries, the
11 logical conclusion has to be that those injuries were
12 inflicted by the person in that exclusive care.

13 One wants to have another explanation.
14 Believe me, nobody likes to think that someone is going
15 to do things to hurt a child. But lacking an
16 explanation of this child being in a car accident or
17 falling from a building or some story that would account
18 for the types of injuries that we have here and the time
19 period in which this child went down, the conclusion has
20 to be that this was inflicted on this child and we're
21 not being given the truth.

22 Q And then also backing that up is your
23 microscopic examination of slides and your explanation
24 to the jury that's consistent also with the timeframe of
25 him being in the exclusive care of the defendant?

1 A Right. This short duration. I mean, "short"
2 in not more than just a few hours of when this injury
3 occurred.

4 Q Now, maybe these injuries right here were
5 caused. I know it's not a bony area. I know the
6 abdomen is compressible, but maybe that's someone, CPR
7 did that, you think that's plausible? The red, this
8 area, right here on State's Exhibit Number 88?

9 A Well, even inappropriate CPR, certainly that
10 can be given to folks, it doesn't make sense that
11 someone would be -- I mean, these have to be from
12 punches and blows to the belly, that you would do
13 punches and blows to the belly for CPR. I mean, that
14 this child just -- it's just not in part of what people
15 have in my view as a way to do CPR.

16 Q In other words, these are -- even if you were
17 doing -- if you were doing CPR correctly, it wouldn't
18 cause it?

19 A That's correct.

20 Q If you were doing it incorrectly over the
21 abdomen with the correct amount of force, it wouldn't
22 cause that?

23 A The only thing that people do as an abdominal
24 maneuver is the Heimlich maneuver, when you think that's
25 something that needs to be dislodged and that's a

1 single, a few short pressure bursts to the belly to try
2 to expel some foreign body.

3 And theoretically that could leave some injury
4 to the belly, but that implies that there was something
5 that brought the child down like an obstructed airway
6 with a foreign body, and we don't have any information
7 to that.

8 (Reported by D. Keith Johnson, CSR:)

9 Q What you have is the torn mesentery in the
10 severity that you've talked about, with these injuries
11 being consistent, overlaying the torn mesentery,
12 correct?

13 A These injuries are consistent with blows to
14 the belly, and the story's consistent, especially with
15 the brain swelling of some duration, not more than a few
16 hours, but some duration of lack of medical attention.

17 And when you have an event like this that --
18 that's an accidental event, medical attention is sought
19 immediately. When you have an event that is being
20 hidden, medical attention is delayed. And the degree of
21 brain swelling and the fact that there is some
22 accumulation of blood and -- and these changes indicate
23 that there was a period of time of hiding things before
24 authorities were called.

25 Q On State's Exhibit 10 up here, you saw the --

1 the bruising on Kelynn's -- without putting up every
2 photograph, the bruising on the back that like was
3 depicted in State's 82, the bruising on the hands that
4 you've seen in State's 91, and there's some other ones,
5 the bruising here in State's Exhibit 83 where he has
6 this bruising around the eye -- and you see this over
7 here on the head?

8 A Okay.

9 Q Yeah. Was all of this bruising -- do you
10 think this bruising on his eye, the clavicle that you
11 saw, the hands, the back, the abdomen, are consistent
12 in -- in when they were inflicted?

13 A Again, it -- it's hard to date timing on
14 bruises. But the fact that all of them have a -- a
15 fresh appearance and that the bruising where we have
16 microscopic -- and that's the internal bruising around
17 the bowel, is also fresh.

18 Yes, one can say that the -- the vast majority
19 of the injuries that you see are contemporaneous,
20 meaning within the same timeframe.

21 Q You can see the bruising on State's 83 on the
22 eye. Let me show you State's Exhibit 10.

23 Do you see the bruising? That's the one that
24 was taken at 9:30 on May 30th. Does he have that
25 bruising on his eye there?

1 A No, he does not.

2 Q Have you taken into -- what's a -- have you
3 ever heard -- well, have you taken into account flash
4 photography and skin tone averages?

5 A No, no.

6 Q Okay. Do you know what that is?

7 A Well, by -- by the nature of the way you're
8 talking about that, the usual requirement for forensic
9 photographs is to have a color scale in the photograph,
10 and so that when you take a picture, you adjust for what
11 the color appearance is by having the -- the color
12 standard. And without that standard, there always is
13 concern over variations in color based on techniques
14 that are used.

15 But even so -- and that's a legitimate
16 criticism of photographs without a color scale with
17 them. But even so, these bruises with these
18 photographs, going by reasonable interpretation of skin
19 coloration and other known color -- sort of standard
20 colors that are there, these pictures seem to be pretty
21 reasonable reproductions of what would expect as a real
22 life appearance. And these bruises have a very fresh
23 look to them, the redness, and the locations are all
24 consistent with them being fresh bruises.

25 Q Are they consistent with having occurred at

1 the same time?

2 A In a timeframe that has some flexibility to
3 it. I mean, you have to -- within the same one- or
4 two-hour time. I -- I couldn't say that they were
5 within five minutes, but they're certainly less than
6 four hours' discrepancy between them. So --

7 Q So these --

8 A -- you can't say with certainty that they're
9 within a very tight time range, but it's -- a few hours
10 is a reasonable thing to say.

11 Q So they could have been inflicted at the same
12 time, they could be as far as a couple hours apart?

13 A That's correct, yes.

14 Q Okay. How quick would a bruise appear?

15 A Well, first of all, the heart has to be
16 beating. The bruise is the presence of blood outside
17 the blood vascular system. And then you have an injury
18 to the vessel that if you sever the vessel or open a
19 hole in the vessel, then the bruise appears right away.

20 If it's an injury because the vessel loses its
21 microscopic integrity, but is not physically torn, then
22 it can evolve over minutes, to some -- some bruises are
23 enhanced over a period of an hour or so as there's a
24 slow leak of blood.

25 Most of us have the experience with smaller

1 compressive injuries that -- damaged some capillaries,
2 that there's a slow leak, and then you know you bumped
3 yourself when you looked there an hour later, and you
4 didn't have a bruise immediately when the bump occurred.

5 Q So if CPR is performed -- well, first of all,
6 you don't think those bruises occurred from CPR?

7 A Now, which -- the ones --

8 Q On the -- (indicating)

9 A No, absolutely not.

10 Q Okay. What do you think about rigor mortis as
11 a dating tool? What do you think?

12 A Well, it's variable, depending on the muscle
13 mass, the external temperature and the physical
14 condition of the person when they died. And, you know,
15 someone who is doing heavy exercise and has sudden
16 death, they'll get rigor mortis much more quickly.
17 Someone who has small muscle mass will have limited
18 rigor mortis. But generally it's said that it takes
19 three or four hours to see the first signs of the -- the
20 contraction, the fixed contraction of muscles from rigor
21 mortis.

22 Q Three to four hours for it to --

23 A For the -- very earliest signs, yes.

24 Q Could be more than that, could be less than
25 that? That's a range?

1 A Yeah. Probably not a lot less. But, yes,
2 that's a range. And the very early signs are in some of
3 the smaller muscle masses.

4 Q Let me show you State's -- let me see if I can
5 find it.

6 THE COURT: Mr. Bingham, while you're
7 looking through the pictures there, I know trying to
8 find one, I believe we'll go ahead -- it's five till
9 12:00. I believe we'll go ahead and take our noon
10 recess.

11 So, Ladies and Gentlemen, if you would
12 please be back in the jury room at one o'clock.

13 All rise for the jury.

14 (The jury left the courtroom.)

15 THE COURT: All right. We'll be in
16 recess till one o'clock.

17 (Lunch recess.)

18 THE COURT: All right. We're back on the
19 record in 241-1251-08, the State versus Demontrell
20 Miller. The State and the defense counsel are present.
21 The defendant is before the Court.

22 Bring in the jury, Carleton.

23 (The jury entered the courtroom.)

24 THE COURT: Be seated, Ladies and
25 Gentlemen. Thank you.

1 All right. Mr. Bingham.

2 Q (By Mr. Bingham) Doctor, you said the -- I
3 think when we left, you said the onset of rigor mortis,
4 given or take, the range in a child is three to four
5 hours?

6 A Right. Depending on muscle mass and activity
7 of the child at the time of death.

8 Q Okay.

9 MR. BINGHAM: May I have one second,
10 Judge?

11 Q (By Mr. Bingham) Let me show you --

12 MR. BINGHAM: May I approach the witness?

13 THE COURT: Yes, you may.

14 Q (By Mr. Bingham) Let me show you State's
15 Exhibit 214. Is this the article that you wrote along
16 with Dr. Kirschner?

17 A Yes, it is.

18 MR. BINGHAM: We'd offer 214.

19 THE COURT: All right.

20 MR. BINGHAM: We provided a copy to
21 defense previously.

22 MR. THOMPSON: May I have the witness on
23 voir dire?

24 THE COURT: Yes.

25 MR. THOMPSON: Thank you.

1 VOIR DIRE EXAMINATION

2 BY MR. THOMPSON:

3 Q Dr. Wilson, the article counsel is talking
4 about that's marked Defense Exhibit 214 --

5 MR. BINGHAM: State's Exhibit 214.

6 Q (By Mr. Thompson) Yeah. State's Exhibit 214.
7 I'm sorry. Is -- let's see -- runs from page 467 to
8 page 511?

9 A JUROR: We can't hear you very well.
10 Sorry to interrupt.

11 Q (By Mr. Thompson) The article that counsel is
12 referring to marked as 214 is a chapter in the book that
13 runs from page 467 to page 511, 40-something plus pages?

14 A Yes, sir.

15 Q Did you have a contribution to the entirety of
16 this article?

17 A Yes, sir.

18 Q And this was a collaborative effort between
19 you and Mr. -- is it Kirschner?

20 A Dr. Robert Kirschner.

21 Q Kirschner?

22 A Yes.

23 Q Okay. So the individual page that Mr. Bingham
24 had taken out initially is not the entirety of the
25 article -- I mean, is not the entirety of your

1 contribution to this article; you had something to do
2 with the entire article?

3 A Yes, sir. It was a collaborative effort.
4 Yes.

5 MR. THOMPSON: Thank you. We have no
6 objection.

7 THE COURT: What number is that --

8 MR. BINGHAM: It's State's Exhibit
9 Number 214.

10 THE COURT: All right. State's Exhibit
11 Number 214 is admitted into evidence without objection.

12 DIRECT EXAMINATION (CONTD)

13 BY MR. BINGHAM:

14 Q And real quick, Page 511 is the -- the one
15 page that we pulled out before, because that was the
16 that you were referring to -- is -- just explain the
17 relevance of that table. It's in evidence. They can
18 read it. But why is that in your article or your
19 chapter of this book that was published entitled
20 "Pathology of Fatal Abuse." Why is that table in there?

21 A The purpose of this table is to help
22 understand the thinking process that is essential to
23 analyzing why a child is dead, and especially why a
24 child is dead when there has been trauma that has
25 brought about the death of the child. And the section

1 that would apply to this child in that table is under
2 Category 3, which is called "fatal injury."

3 Q Okay.

4 A This child died as the result of what was
5 evident to be blunt force trauma to the belly with
6 injury to the belly that led to the death. And fatal
7 injury doesn't necessarily mean that someone murdered a
8 child. But there's a process of evaluation that needs
9 to take place.

10 So an autopsy can determine that the child
11 died from injury, which is the case for this child. But
12 then there's an investigation that takes place, and
13 that's the next section.

14 Q Okay. That middle section right here?

15 A Yes.

16 Q Okay.

17 A In that investigation, if the investigation is
18 negative from a culpability point of view, you can say
19 that the injury is consistent with some sort of
20 accidental event, an accident in the general sense
21 meaning something that happened that could not have been
22 prevented, something that happened that in a sense is an
23 act of God, an act of circumstance, but an act of
24 circumstance where there's no negligence or infliction
25 involved. It's something out of the blue that occurred.

1 If the investigation is inconclusive in terms
2 of finding is this something that was an accident or is
3 this something that was inflicted on the child, then the
4 conclusion is that this is an undetermined death. It's
5 still a death from injury, but undetermined.

6 And if the investigation comes up positive in
7 the sense that the injuries involved that brought about
8 the death are injuries that, either by witness or
9 confession, are overtly inflicted -- in other words,
10 that you would have statements by people or even someone
11 who's being accused of doing the injuries, that they did
12 indeed do the injuries, then that's what man brought
13 about to man, or if the injuries are such for which
14 there is no compatibility between the story and the
15 death, then, again -- and that's where the injuries are
16 inconsistent with -- the story is inconsistent with the
17 injuries.

18 And that's really what we have in this case,
19 and that is that we have a story of a child who was
20 alive and well and functioning right up to the time
21 where he is found basically poorly responsive or
22 unresponsive, and he has these multiple injuries that
23 are not accounted for by the story in the setting of
24 being under the sole, exclusive care of an adult
25 caregiver.

1 In that situation, where there is
2 inconsistency with the injuries -- in other words,
3 multi-site injuries, those injuries account for the
4 death, because it's the traumatic injury to the belly
5 which is what killed this child, that you have no story
6 to account for those injuries, then you have to conclude
7 that this is a homicide, from a medical classification
8 of homicide, which means what man did to man to bring
9 about death.

10 And we're not talking issues of intentionality
11 from the medical point of view. We're talking about
12 where is the responsibility for why this child is dead.
13 We have fatal injuries. They are injuries where the
14 story we have is inconsistent with the injuries. And
15 the story of this child being well up to the point of
16 being in a swimming pool and then being found in
17 basically an unresponsive state in that swimming pool,
18 that doesn't make sense with the findings of the child.

19 So the conclusion by exclusion is that it's
20 what man did to man, what a person did to a child, and
21 we don't have the truth in the story about how that
22 occurred.

23 But because of the injuries, because they're
24 multimodal -- in other words, multi-site injuries,
25 because those injuries are there and they're not

1 accounted for and they did not preexist someone else's
2 care, the only conclusion is that the adult who was with
3 this child during the period of time when those injuries
4 occurred was responsible for inflicting those injuries
5 on that child.

6 MR. BINGHAM: We'll pass the witness,
7 Judge.

8 THE COURT: Mr. Thompson.

9 MR. THOMPSON: Thank you, Your Honor.

10 (Reported by Steve R. Awbrey, CSR:)

11 CROSS-EXAMINATION

12 BY MR. THOMPSON:

13 Q Hello, Dr. Wilson.

14 A Good afternoon, sir.

15 Q How are you doing?

16 A I'm okay. Tired, but thank you for asking.

17 Q Do you need a minute?

18 A No, I appreciate that. I'm okay.

19 Q Now, we have not had an opportunity to talk at
20 all about this case, have we?

21 A No, sir, we did not talk together.

22 Q As a matter of fact, I was informed by the
23 District Attorney's office that you didn't want to talk
24 to me?

25 MR. BINGHAM: That's not true.

1 Q (By Mr. Thompson) -- unless he was present or
2 talk on the telephone; is that true?

3 A Well, I don't know what he said to you.

4 Q Let me rephrase the question.

5 Did you decline to speak with me concerning
6 this case unless I was with the District Attorney?

7 A No, sir. In fact my practice is, and I've
8 made this clear to this District Attorney and other
9 District Attorneys that I don't work for a side, but I
10 make myself available to people if they want to call me
11 and talk to me about a case. I'm available.

12 Q Okay. Let me understand this very clearly.

13 It was never your position that you would not
14 talk to the defense unless the State was present or with
15 you on the telephone?

16 A I like to have the State there, if that's
17 convenient, but I don't restrict myself to talking to
18 the defense without a representative from the State
19 being present.

20 So I would not have said that, that I cannot
21 be available if there's not someone from the District
22 Attorney's office available.

23 Q Okay. So it's your statement that you didn't
24 tell Mr. Bingham that?

25 A I would have not said it that way.

1 Q Well, you didn't say it or you didn't say it
2 that way?

3 A No. I would always be available to talk to
4 you. If the prosecution is not available, I would still
5 be available to talk to you. I probably -- if
6 there's -- I don't remember such a discussion, but in
7 other cases, I've always said, I would be glad to talk
8 to the defense. I make myself available to talk to the
9 defense. If the prosecution is available, that's good.
10 If not, I would still talk to the defense. I didn't
11 operate any differently in that case than all of the
12 other cases where I've been helping out the prosecution.

13 Q Okay. How often do you testify for the
14 defense in cases such as this?

15 A Overall where I actually go to trial and
16 testify maybe 20 percent of the time. A lot of the
17 times I get involved with defense where they come to see
18 me and go over a case, and I tell them what the evidence
19 shows to me, help them understand the medical evidence,
20 and then because the medical evidence in their case is
21 damning of their client, they don't want me to testify
22 in court. But I make myself freely available. I don't
23 charge ever for that whether the defense or
24 prosecutor -- I'm just mentioning that. I don't
25 discriminate on sides. I make it a point to just to try

1 to help understand what the evidence shows about why a
2 child who should not be dead is dead.

3 Q Okay.

4 You belong to -- you are a member of a
5 committee that reviews deaths of children in this State?

6 A That is correct, sir.

7 Q That's sort of a child advocacy program, or is
8 it part of the child advocacy program?

9 A In our county, city and county, we function in
10 that review of death -- review of children's death in
11 the child advocacy center, so it's based there, yes.

12 Q That's a statewide program?

13 A Yes, it is. And I actually participated in
14 helping set that up in Texas when I moved to Texas.

15 Q And you-all reviewed the data -- I mean, the
16 program actually reviewed the data that would have been
17 reflected of this case?

18 A No, not at all. This is a private case for
19 me.

20 Now -- I'm going to make a presumption that I
21 don't know the facts of, but there should be a
22 comparable group for this area that at some point should
23 have gone over this case, but I've had no connection
24 with that group in this part of Texas related to this
25 case.

1 Q So it's not like you've reviewed some data
2 that you received relative to this case and then called
3 the District Attorney's office and said, hey, I would
4 like talk to you?

5 A Oh, not at all. In fact, they cold called me
6 regarding is this case, which I get cold calls like that
7 on a regular basis throughout the week.

8 Q How did they know you were available, do you
9 have any idea?

10 A Because I've done this before in this
11 jurisdiction and jurisdictions all over Texas and in the
12 United States.

13 Q You've testified in Smith County for
14 Mr. Bingham before?

15 A Yeah, I believe I was involved in at least one
16 case in this county before a number of years ago. I
17 don't remember the details of that case, but I mean
18 that's not an uncommon thing.

19 Q And you don't remember how long ago it would
20 have been?

21 A I've been in Texas for 15 years, 14 years,
22 now, so sometime in that timeframe, but you know maybe 5
23 or 8 years ago. I really don't know.

24 Q You can remember you testified in a case in
25 Smith County, but you don't remember how long it was?

1 A Right.

2 Q And you don't recall the case?

3 A I would with prompting recall the case. It's
4 just, I get involved in reviewing a lot cases and try
5 not to keep them in my current memory.

6 Q And 80 percent of cases that you deal with as
7 far as testimony is concerned that testimony is
8 generally for the State?

9 A That is correct.

10 Q Okay. You are a pediatric pathologist?

11 A That is correct.

12 Q Okay. You are not a forensic pathologist?

13 A That is correct.

14 Q Okay. At what point do you do autopsies?

15 A On a regular basis when a child dies in the
16 hospital, either at the hospital where I work, or I do
17 autopsies at the medical school for the county hospital.

18 Q But are you board certified in anatomic
19 pathology?

20 A Yes, sir.

21 Q Clinical pathology?

22 A Yes, sir.

23 Q Pediatric pathology?

24 A Yes, sir.

25 Q And pediatric hematology?

1 A It's actually heme oncology.

2 Q One of those ologies?

3 A Yes, sir, and pediatrics.

4 Q And pediatrics?

5 A Yes.

6 Q But you're not board certified as a forensic
7 pathologist.

8 A That is correct, sir.

9 Q But you do autopsies?

10 A Right. Remember now anatomic pathology
11 includes autopsies, that's part of anatomic -- you have
12 to be an anatomic pathologist before you become a
13 forensic pathologist.

14 Q Okay. But you do autopsies for counties? I
15 mean, when a Justice of the Peace in this state in a
16 county in this state refers a body to a medical
17 examiner, would you be one of the persons that they
18 would send the body -- I mean, do you work at one of the
19 places where they would send the body and expect an
20 autopsy and a finding similar to that of what you have
21 from Dr. Quinton?

22 A Not now, but for several years I provided that
23 service on a volunteer basis to the El Paso County
24 Medical Examiner's Office.

25 Q You were a volunteer pathologist, forensic

1 pathologist?

2 A No, I was not -- I'm not boarded as a forensic
3 pathologist. I'm a pediatric pathologist and help them
4 do a good number of their pediatric cases for a period
5 of time.

6 Q So your autopsies would have been -- whatever
7 autopsies you've done, would have been limited to
8 pediatric autopsies?

9 A Well, in the hospital -- for helping out the
10 medical examiner's office, and I used to do that also in
11 Denver when I was there. It would just be pediatric
12 autopsies, but in the practice that I have, in the
13 hospital where I work, I also do occasional adult
14 autopsies.

15 The things about autopsies, it's not a
16 procedure that a lot of pathologists want to be involved
17 in. So if like me you have an interest in trying to
18 figure out why people die, you tend to be the person
19 that people ask to do the autopsies.

20 Q You would be the person who would do like a
21 private autopsy? If I wanted to know why somebody I was
22 related to died, I could hire you to do an autopsy?

23 A Right. I don't do autopsies for hire. If a
24 child dies and people want information about that, and
25 actually there's a situation like this waiting for me

1 right now when I get back to El Paso. There's a
2 question that a family wants to know why a child died,
3 and so they're going to bring the body to the hospital.
4 And when I get back, I'll be doing the autopsy, and you
5 can say maybe that's a private autopsy, but it's an
6 autopsy to help them understand what happened to their
7 child.

8 Q But doesn't El Paso County have a medical
9 examiner's office?

10 A Yes, they do, but --

11 Q But isn't the medical examiner in El Paso
12 County a board certified forensic pathologist?

13 A Yes. And yes to both of those questions.

14 Q Why do they need your help to do an autopsy?

15 A Well, that's where the specialty of pediatric
16 pathology comes in, because the majority of deaths of
17 children even ones that go to a forensic facility, are
18 still due to natural causes. That's where pediatric
19 pathology is involved in understanding natural deaths.

20 Q And would it be your position that a skilled
21 forensic pathologist doesn't have enough where-for-all
22 to look at the tissues that you look at to look at the
23 slides that you look at and come to the conclusion that
24 this child died of bronchopneumonia or that this child
25 died of a gunshot wound or this child died -- they

1 couldn't do that, so they need you?

2 A It is not my position as a general statement
3 that that can't be done. But I can tell you that the
4 standard approach to trauma related deaths that applies
5 to adults in general, does not apply to children.

6 Q Why?

7 A Because it's a different world. Children are
8 a different world. Their tissues are different. Their
9 development issues are different, and there are things
10 that bring about the death of children that are not
11 related to guns and knives.

12 And because of that, the standard forensic
13 pathology approach is not always the best approach to
14 look at why a child is dead.

15 Q Well, I don't understand. Are you telling me
16 that Dr. Quinton couldn't look at the iron stain on the
17 slide that you looked at and tell that was a date of
18 injury?

19 A I'm not saying that about that specific point.

20 Q Are you saying that Dr. Quinton couldn't look
21 at the stain on the slide from the bone cut that you
22 looked at and tell the same thing that you testified to
23 with respect to that?

24 A No, I'm not saying that.

25 Q Is it your position that Kelynn is a child and

1 Dr. Quinton does autopsies, I believe, on children. He
2 did this one. That Dr. Quinton could not look at the
3 same slide that you looked at which has the presence of
4 white blood cells as well as the red blood cells and
5 make the same analysis that you made?

6 A I don't want to individualize it to this
7 particular doctor, but the process of analysis is one
8 where you take information, you put the information in
9 the context, and then you make an interpretation. And
10 acquiring the information is a pretty standard process.
11 Putting that information into a context does somewhat
12 depend on your knowledge of the context, and with
13 children that knowledge, clues, issues of growth, and
14 development, and then making an interpretation can --
15 you can come up with a different result.

16 Since most deaths of children are not due to
17 standard forensic issues, but they're due to medical
18 issues, they're due to developmental issues. They're
19 due to malformations. There's a lot of range of
20 pediatric medicine that is not standard in the forensic
21 approach. One has to have a balanced understanding of
22 those issues.

23 Where the forensic pathologist in general is
24 deficient is they're knowledge of basic pediatric
25 issues. Pediatric developmental issues. Where I am

1 deficient from a forensic point of view is that I'm not
2 a person that should do an autopsy on someone who has
3 had gunshot wounds, for instance, that's not something
4 that is in my training and experience to deal with
5 interpreting gunshot wounds, but for death where trauma
6 is involved, trauma that's inflicted at the hand of
7 another with a child, that's something that is very much
8 in the area of pediatrics and pediatrics evaluations.

9 That's why pediatricians are the ones that are
10 involved when children are alive in interpreting child
11 abuse. That is done by folks with pediatric training.

12 Q There were a lot of words spoken just then,
13 okay.

14 Let me see if I can filter out what that
15 means.

16 Does that mean that you have been able to see
17 something in your examination of the slides and autopsy
18 photographs because this is a child that Dr. Quinton was
19 not able to see? That's a question in a few words.

20 A What I have been able to do is to put the
21 death of this child in the context of the caretaking
22 setting in which the child existed when it died.

23 Q Can we put a pause there?

24 A Yes.

25 Q What -- and if I understand what you just

1 said, what you've been able to do is take the story and
2 put it in some kind of context, so that from your
3 perspective, it makes sense?

4 A That's right. The findings put in the context
5 of the story. You're saying that very well.

6 Q But, what you've testified to --

7 MR. THOMPSON: May I approach?

8 THE COURT: Yes.

9 Q (By Mr. Thompson) -- was already put in this
10 extremely long context long before you arrived. This
11 already existed. All you did is sit here and confirm
12 what Mr. Bingham has already had written up on the
13 board. What did you add to this scenario that wasn't
14 there previously?

15 A Sir, the thinking on this case has been one of
16 exchanging ideas and talking about things.

17 Q With counsel for the -- State's counsel?

18 A That is correct.

19 Q Right.

20 A And I would like to think that I contributed
21 into the dynamics of that process of evolving this
22 perspective of this case.

23 Q This whole story, this whole scenario, you
24 collaborated with counsel to come up with this story
25 that's outlined on these writings that he's put up on

1 the board?

2 A I've had input into providing the perspective
3 of pediatric pathology on why a child that is injured
4 can function or not function in certain settings with
5 that injury, that is correct.

6 Q And therefore there should be no surprise to
7 anybody that your story is consistent with what's
8 already on the paper, would that be fair?

9 A Well, right, if there wasn't a consistency,
10 then I wouldn't be here testifying.

11 Q You put great store in historical data. You
12 believe it's extremely significant in understanding the
13 nature of injuries?

14 A By "historical" you mean in the story about
15 what happened.

16 Q The story?

17 A Yes, that's important.

18 Q What if the story is a lie?

19 A Well, that's one of the things that one needs
20 to try to figure out.

21 Q How would you figure that that out?

22 A By relating what's known of the mechanism of
23 injury or disease to what is being said about the way
24 the child was.

25 Q But you get the story secondhand?

1 A Everyone gets the story secondhand.

2 Q Not everybody, not the people who go out and do
3 the investigation?

4 A It's still secondhand, because it's from
5 interviews of the people involved.

6 Q And you have to assume that the information
7 that the people are involved -- the information that the
8 people who are involved gives you is the truth, right?

9 A I don't see that you assume that. What you're
10 doing is that you're trying to have an open mind.

11 Q Okay.

12 A And you're collecting information is the way
13 to look at that. And then you can sit down later when
14 you have different sources of information and try to see
15 what makes sense and what doesn't make sense.

16 Q Let's assume, hypothetically, that we are --
17 we've got an open mind, hypothetically, our minds are
18 open?

19 A Okay.

20 Q We haven't reached conclusions about, you
21 know, the fact that somebody accused of a crime is the
22 perpetrator simply because he was the last one with the
23 child or that he was hiding stuff and that kind of
24 stuff. We haven't reached those conclusions. We've got
25 an open mind?

1 A Okay.

2 Q Now, let's talk about the rib fracture, okay?

3 A The rib fracture?

4 Q Yes.

5 A Yes, sir.

6 Q I believe your testimony was that you believe
7 that the rib fracture was at least 14 days old or older,
8 the initial rib fracture?

9 A Right, that is correct.

10 Q And if you had information that this child was
11 in the presence of his grandparents 14 days prior to his
12 death what conclusion could you draw from that,
13 hypothetically?

14 A Well, first of all, the 14 days is not a rigid
15 thing, but let's say if you had the information that the
16 person that was involved with the child at the time of
17 death had not been involved with the child prior to
18 that, let's just say that hypothetically, so that you
19 would say that that was a rib fracture that this child
20 got that was unexplained, but as an unexplained injury,
21 it raises a red flag. But it could not have been done
22 by the person that was with the child when the child
23 died. So that would allow you to conclude that, but I'm
24 not saying that this occurred exactly two weeks before
25 hand.

1 Q Right. It just seems odd to me that we can
2 make pretty certain estimates, but if the estimate in
3 time points to somebody other than this person, then we
4 start fluffing off and saying things like, well, that's
5 not a hard-and-fast rule. It could be less than 14
6 days, right?

7 A I didn't make a rigid estimate --

8 MR. BINGHAM: I object. Ask that he be
9 allowed to finish.

10 THE COURT: Let him finish, Mr. Thompson.

11 A I'm sorry. If I conveyed that, I did not mean
12 to convey that. This is not a rigid point in time. The
13 old rib fracture, the evidence of old rib fracture is a
14 range from several days to up to several weeks,
15 somewhere in there. It's a range of time. It's not an
16 exact dating and time. And, in fact, that's one of the
17 issues with the fresh injuries, that's a range, too.
18 Instead of talking about days, we're talking about
19 hours. But in pediatric cases, especially what becomes
20 important, is to relate the child's response and
21 functionality to when an event may have occurred.

22 And so with a rib fracture, you look for a
23 story of when this child had a period of time of
24 irritability or decreased activity and sensitivity over
25 the area where the rib was, and that would give you a

1 sense of when the injury might have occurred.

2 Q If you're dating an injury like you've dated
3 this injury to put it within a range of time when my
4 client was alone with the child, if you are dating an
5 injury and your conclusion is that that injury could
6 have been 10 to 14 days old and you have evidence that
7 somebody other than my client was with the child, during
8 that period of time, why do we need to now say, well,
9 this could be anywhere from two or three days old to 10
10 or 14 days old or three or four weeks old. Why do we
11 need to change that range of time, once we found out
12 that somebody other than the accused could have possibly
13 caused the injury --

14 MR. BINGHAM: -- my only objection is --

15 Q (By Mr. Thompson) -- If we're being objective?

16 MR. BINGHAM: My only objection is to the
17 part of question is the statement that you dated the
18 injuries to put it when the defendant was alone with the
19 child. That's not his testimony. That's my objection.

20 THE COURT: Just rephrase it

21 Mr. Thompson.

22 Just go back through it. Just rephrase
23 it and that will take care of the objection and try to
24 get it the way he's testified to it like you did the
25 first time.

1 Q (By Mr. Thompson) Is it your testimony now,
2 okay, that the old rib injury could be anywhere from
3 three days to three weeks old?

4 A Well, it was never my intent to make my
5 testimony viewed as a rigid thing that it was a two-week
6 old injury. It is my testimony that there's a range of
7 time. It's had reactivity and the reactivity of several
8 days to a few weeks, yes.

9 Q How long in your opinion does it take for that
10 calcium to form in the bone and that little rigid area
11 to appear, so you can make an approximate date to that
12 injury? How much time has to elapse.

13 A That's a good question. The word is actually
14 "callous".

15 Q I'm sorry.

16 A It's a different meaning from personality
17 callous. It's the actual term that applies to the
18 body's reaction to try to heal a fracture.

19 And that takes several days. You know you
20 will start seeing changes in two or three days. It gets
21 thicker and more supportive after a week, and it can
22 last actually once the bone is healed, but you can still
23 have the callous there for up to weeks or months
24 afterwards. And there's some variability depending on
25 nutrition and age and activity and all of those things,

1 but it's a range of a few days to a few weeks somewhere
2 in there where this particular callous formation falls.

3 Q Okay. And the fresh blood that appears inside
4 the fracture which indicates refracture, would have
5 occurred when?

6 A It's just that, fresh blood. And it would
7 have occurred within a few hours to no more than a day.

8 Q Could it have been minutes?

9 A Yes.

10 Q Could it have been within minutes after the
11 child died?

12 A Well, once the heart is not beating, you're
13 not going to get blood outside the vascular system in a
14 site like that, but I mean -- you're thinking is
15 correct. When the child is alive, and you have an old
16 fracture and if that fracture gets reinjured, you will
17 have fresh bleeding into that fracture site.

18 Q And hypothetically, if you had information,
19 factual information based on testimony from the
20 firefighter himself who hit the child in the back trying
21 to clear his air passage, what would that tell you about
22 whether or not my client inflicted that injury?

23 A Could you ask that question again, so...

24 Q Hypothetically, if you had information, part
25 of your story?

1 A Yes.

2 Q The correct story -- if you had information
3 that during the period of resuscitation, a firefighter
4 hit the child in the back in an effort to try to clear
5 his pathway, and you had -- I'm going add something?

6 A Sure. That's fine.

7 Q That I didn't have in my previous question?

8 A Yes.

9 Q And you had information from the forensic
10 pathologist who did the autopsy. Okay. That in his
11 opinion that reinjury could have come from the attempts
12 to resuscitate the child. Would that change your
13 conclusion at all with respect to whether or not my
14 client caused that rebreak?

15 A With respect to?

16 Q To whether or not my client caused that
17 rebreak?

18 A I cannot say what caused that rebreak in terms
19 of who did that. Let me just tell you that if blood is
20 circulating by CPR and there is impact at that site
21 during CPR, the heart was not beating, because we do
22 have EMS reports that they could not reestablish the
23 heartbeat. But they were attempting to reestablish
24 circulation, which is separate from a heartbeat. That's
25 the whole point of doing chest compressions, and if they

1 reestablished circulation and if the site was made
2 vulnerable by some type of impact or compressions, yes,
3 it would be possible to have some bleeding at that site
4 if they are getting circulation with their CPR.

5 So you're asking a legitimate question, and
6 can a site that gets sort of secondarily injured during
7 CPR that already had its vulnerability because it was a
8 healing site and you reestablished circulation, can you
9 get fresh blood looking like a new injury at that site,
10 the answer would be, yes, to what you're saying.

11 Q What would your conclusion then be about the
12 possibility of my client having caused that reinjury?

13 A Well, then you would say that old injury
14 became traumatized by the CPR and that there was enough
15 circulation established by the CPR, not by the child's
16 heart, so that there was bleeding at that site, and then
17 it would take that particular site as out of the picture
18 for related to injuries inflicted on this child around
19 it's death.

20 Now, let me just say that that site is not in
21 any way responsible for the child's death. But you
22 raise an absolutely valid point about that if you
23 reestablish circulation partially with CPR and there's
24 trauma associated with the CPR that injures a previously
25 injured site in the bone, yes, you could have some

1 secondary bleeding that would be fresh bleeding there
2 that would occur, and it would look like it was part of
3 the overall trauma. So I agree with what you're saying.

4 Q Okay. And in your story, hypothetically, if
5 you had information in the story that the child spent
6 more than 50 percent of his time with his grandparents.
7 They had him virtually all the time. They had him a
8 week or so before his death?

9 A Okay.

10 Q Okay. Would the people in that household have
11 had an equal opportunity to commit the incidents of
12 abuse that you've described here today?

13 A Oh, of course, in terms of timing when care
14 and control of the child, they would have had that
15 opportunity, but by the timing of the injuries -- in
16 other words, these are acute injuries unless there's
17 something wrong with the story about your client being
18 the one being the one in sole care and control of this
19 child during that four-hour period of time or so when
20 these injuries occurred, that doesn't apply.

21 You're general statement is a valid statement,
22 but the injuries are not consistent with that statement.

23 Q Well, let's talk about this. You always seem
24 to come back to the timing, and when it puts my client
25 alone with the child so he could be the only person who

1 could have inflicted these injuries, the timing always
2 seems to be four hours or less?

3 A Okay.

4 Q But then we say that these are not
5 hard-and-fast times?

6 A Okay.

7 Q We say these times are variable?

8 A But there's a range, yes, sir.

9 Q There's a range in these times?

10 A Yes.

11 Q And one medical examiner might testify that
12 the range is 24 to 30 hours?

13 A Well, I would disagree with that. I mean, the
14 pathology evidence is not consistent with a range like
15 that.

16 Q But then you're not a forensic pathologist?

17 A No, I'm not a forensic pathologist.

18 Q And another doctor who is a forensic
19 pathologist and who is the chief forensic pathologist at
20 the office which he works, might time the injuries as
21 long as and 24 to 48 hours. You would disagree with
22 that?

23 A I would disagree with that, yes, sir.

24 (Reported by D. Keith Johnson, CSR:)

25 Q But then you're not a board certified forensic

1 pathologist, are you?

2 A That's correct.

3 Q Right.

4 MR. THOMPSON: May I approach?

5 THE COURT: Yes.

6 MR. BINGHAM: What page?

7 MR. THOMPSON: Quinton, 46.

8 Q (By Mr. Thompson) Have you seen this document
9 before?

10 A Can I bring it closer to me?

11 Q Sure. I'm sorry.

12 A It's a transcript of the -- an interview of
13 the doc. at the Medical Examiner's office.

14 Q Yeah.

15 A Yes, okay.

16 Q Have you been provided with that?

17 A Yes, I have seen it.

18 Q And you've read that before?

19 A I have. I mean, I -- I'm not prepared to take
20 a quiz on it, but --

21 Q Sure, I understand. And I refer you to
22 Page 46 in that transcript, okay?

23 I believe in your testimony that -- let me
24 just give you a second and ask you to read this.

25 A Okay. I just have to bring it closer.

1 (Witness complies.)

2 Q And would you read this.

3 A Sure.

4 Q This paragraph here.

5 A Okay. (Witness complies.)

6 Q Okay. And did you read this? This paragraph?

7 A Yes.

8 Q Okay. Now, I believe that you said that when
9 you examined -- you didn't examine the body, though, did
10 you? You just looked at the pictures?

11 A That's right, and the slides.

12 Q And the slides. Dr. Quinton examined the
13 body.

14 A Yes.

15 Q And were you aware of the fact that in the
16 course of his examination, he found that there was
17 organizational -- there were organizational changes in
18 the blood and in the body, you know, which reflected
19 inflammation? Were you aware of that finding?

20 A There are not organizational -- see, there's
21 evidence of old injury. We've talked about that, the
22 old injury of the bone and then the area where there was
23 iron deposition in the belly of that section. And those
24 are old injury sites. But all the new injury sites
25 fresh, within a few hours.

1 Q Well --

2 A And so you would not apply the term
3 "organization" to the new injury sites. You would apply
4 it to the old injury sites.

5 Q So Dr. Quinton, who is a board certified
6 forensic pathologist, is mistaken with respect to the
7 statements he made in this --

8 A Well --

9 Q -- in his grand jury testimony?

10 A Well, the issue here is superimposed old
11 injury and fresh injury.

12 Q But he didn't talk about superimposed old
13 injury or fresh injury.

14 A And I would consider that that was a mistake
15 on his part.

16 Q Okay.

17 A And let me just comment that it's not forensic
18 pathology but regular pathology that deals with the
19 process of evaluating injury.

20 Q But how does the fact that you deal with
21 pediatric psychology --

22 A Pathology.

23 Q Pathology -- I'm sorry.

24 A That's all right.

25 Q -- equip you to make that assessment, when the

1 board certified forensic pathologist didn't see that?

2 A You said it right.

3 Q Is that because you are a pediatric --

4 A Pathologist.

5 Q -- pathologist?

6 A And the answer to that is inherent in the
7 question that you asked, that children are not adults.
8 The processes of healing, the processes of injury are
9 not the same as in adults. The timeframes are
10 different. The reactive sequences have their
11 differences, and they're developmentally related, so
12 that what happens in a newborn is not the same as an
13 infant, which is not the same as a toddler. There are
14 changes in these processes, and that's why there's a
15 whole discipline of pediatric pathology.

16 Q And you wouldn't expect either Dr. Pustilnik
17 or Dr. Quinton to know, being medical doctors
18 themselves?

19 A Okay. Well, then, the same question would
20 apply to me dealing with the stuff that they're dealing
21 with. The idea is -- yes, they would know that, but
22 they've not specifically studied that.

23 Q So if both of those doctors concurred with
24 reflect -- with respect -- it's after lunch -- with
25 respect to the presence of inflammation, then they would

1 be wrong and you would be right?

2 A I don't want to make it be so blatant. But
3 the inflammation that occurs in infants is not the same
4 as in younger kids and it's not the same as in older
5 kids.

6 The cells involved are different, the
7 processes involved are different, because the -- the
8 tissues are different. And that's why there's a
9 specialty of pediatric pathology.

10 Q And moving on. And if Dr. Quinton was of the
11 opinion that there was evidence of early healing type
12 changes and evidence of necrosis, which means that the
13 issue -- some tissue is dying, and that all of that
14 stuff takes time, okay, which would indicate that this
15 injury occurred at a much longer period of time, he
16 would be mistaken in reaching that conclusion?

17 MR. BINGHAM: I'm going to object to
18 that. That is not his testimony. His testimony was it
19 could be consistent with.

20 MR. THOMPSON: I didn't ask him about his
21 testimony. I just asked him if that was his finding, if
22 that was his conclusion.

23 THE COURT: Just a minute. Are you
24 asking him about -- are you asking this witness what his
25 testimony is?

1 MR. THOMPSON: No. I'm asking this
2 witness if hypothetically, if that was Dr. Quinton's
3 conclusion, would he be correct or in his opinion, would
4 he be wrong?

5 THE COURT: Okay. Well --

6 MR. BINGHAM: Well --

7 THE COURT: Go ahead.

8 MR. BINGHAM: Our objection is we would
9 like him to state Dr. Quinton's correct conclusion.

10 THE COURT: Your objection is to the form
11 of the question of what you're stating Dr. Quinton --

12 MR. BINGHAM: Yes, sir.

13 THE COURT: You got his testimony.
14 Maybe -- maybe go to it when you get a chance.

15 Q (By Mr. Thompson) Let me ask you a
16 hypothetical question.

17 A Yes.

18 Q If Dr. Quinton reached a conclusion, okay,
19 that there was evidence of necrosis and healing, and
20 that these processes after an injury within the body
21 take time and he related that to the timing of the
22 injury itself, would that be an incorrect conclusion, in
23 your opinion?

24 A Yes and no. And let me just tell you. The
25 evidence that we've already talked about is that there

1 is fresh injury in the belly with fresh blood and tissue
2 in which there's little to no reaction to the fresh
3 blood. And that's the acute hemorrhage from a recent
4 injury of just a few hours' duration.

5 But superimposed on that in some areas is
6 evidence of reactivity, iron deposition, of old injury,
7 remote injury. And what you've got, then, is this --
8 the superimposition of fresh and remote. And when you
9 have that, it can be confusing. If you say, "Oh, well
10 this has all been there for a long time," what this
11 child has is evidence that there has been injury in the
12 past.

13 We talked about the old rib fracture, and we
14 all acknowledged that. And you just brought up the fact
15 that could you get fresh bleeding in that because of
16 something done during CPR, even with a stopped heart.
17 And that's a valid observation.

18 But the types of bleeding that is in the belly
19 is from acute hemorrhage and trauma that brought about
20 the death of this child, and that's not from anything
21 related to CPR or even false CPR.

22 So to say that because there's evidence that
23 this child was injured in the belly weeks or even a
24 month ago or several months ago, that there's not
25 evidence that the child was injured in the belly within

1 a few hours, is not a correct thing to say. And so
2 that's what I'm saying about what you said doesn't make
3 sense.

4 It's a combination. There's a -- one area of
5 old injury, or remote injury, but there's a wide area of
6 very fresh injury.

7 Q So if it was Dr. -- hypothetically --
8 hypothetically, if it was Dr. -- if Dr. Quinton had an
9 opinion that the injury which caused the child's death
10 was at least a day old, based on your findings, that
11 would be an incorrect conclusion?

12 MR. BINGHAM: And I'm going to object.
13 That is not the testimony of Dr. Quinton.

14 THE COURT: I'm going to sustain that
15 objection, Mr. Thompson.

16 MR. THOMPSON: I can read the -- the
17 thing from the transcript.

18 THE COURT: Well, you're asking a
19 hypothetical. If you've got something in front of you,
20 read it.

21 MR. THOMPSON: Okay.

22 Q (By Mr. Thompson) You said you've had an
23 opportunity to review this transcript, haven't you?

24 A Yeah. And you just gave me a refresher here.

25 THE COURT: Why don't you give line and

1 page so I can save -- where are you?

2 MR. THOMPSON: Page 46, line -- start
3 with line 2.

4 May I approach? Because he doesn't have
5 a copy of the transcript. I'd like for him to be able
6 to see it when I --

7 THE COURT: Yes.

8 Q (By Mr. Thompson) So here on page 46 of
9 Dr. Quinton's transcript, which you said you've already
10 seen and read?

11 A Awhile back, yes.

12 Q All right. He says, "This is the type of
13 injury, abdominal injury -- this type of injury can
14 linger. So you can live for hours."

15 Am I correct?

16 A Both what you're reading is correct and --

17 Q Okay. Let me --

18 THE COURT: Mr. Thompson, I'm sorry to
19 interrupt you. But he's looking over at you, and the
20 microphone is over here. So everybody on the jury can
21 hear --

22 MR. THOMPSON: Okay.

23 Q (By Mr. Thompson) Then he goes on to say,
24 "I've seen kids live for days." And he's talking about
25 with this kind of injury.

1 A I agree.

2 Q You agree with that?

3 A I agree.

4 Q Okay. "It just depends upon the injury, but
5 it's certainly not immediate."

6 A I'm not quite sure what he means when he says
7 not immediate, if he's talking about this type of
8 injury, in terms of -- it's a little vague what's meant
9 by -- when he says it's not immediate. I'm not sure
10 what the point is on that, but that's okay.

11 Q Okay. Let's skip down to line 9. "I don't
12 think -- again, I don't think this is -- this is
13 immediate cause of death. So I don't think he died
14 within minutes of the injury. And yet it's possible,
15 not more than I would say a day or so."

16 A Okay.

17 Q Is that his testimony?

18 A Yes.

19 Q Okay. And, of course, being the pathologist
20 who cut open the belly, who had an opportunity to look
21 at the blood, who had an opportunity to -- by the way,
22 you didn't -- was there a -- was there a -- was the
23 mesentery taken out and retained somehow so you could
24 actually look at the mesentery when you got there?

25 A My understanding was that the -- that there

1 was not gross tissue. But no, I cannot answer that for
2 sure. They would have retained some fixed tissue for
3 some period of time. But whether that still exists or
4 not -- what was retained or what is retained is the
5 tissue that's in the blocks that are used to make the
6 microscopic slides.

7 Q Okay. So you didn't get a chance to look at
8 the mesentery --

9 A At the gross --

10 Q -- as it appeared to --

11 A That's correct, yes.

12 Q But the board certified pathologist who
13 performed the autopsy did get to look at it?

14 A Yes, that's correct.

15 Q And in his opinion, the injury would not be
16 more than a day. Not four hours. At least possibly a
17 day. And in your -- your opinion, your conclusion is
18 that's -- your opinion is that's incorrect, because your
19 conclusion is this would have had to have happened
20 within four hours?

21 MR. BINGHAM: Judge, I'm going to object.
22 That's not what the testimony says. It says not within
23 minutes, no more than a day. And at the very bottom --
24 I'm going to ask you to read the full part of it --

25 THE COURT: Read it all out,

1 Mr. Thompson.

2 MR. THOMPSON: Judge, he gets to take the
3 witness on cross-examination.

4 THE COURT: Well, it's his witness. He'd
5 have to take him on redirect.

6 MR. THOMPSON: I'm sorry. Redirect.

7 THE COURT: Just go ahead -- if you've
8 got it right in front of you, let's go ahead and get it
9 read where we can go ahead and move on.

10 Q (By Mr. Thompson) Well, okay. The rest of his
11 testimony, which you've already said you disagree with,
12 is there's evidence -- well, he says "there's" -- and
13 then he says "There's evidence of early healing," okay?
14 Changes and evidence of necrosis, which necrosis meaning
15 dead tissue takes time.

16 And you've already said you disagree with
17 that, right? That evidence's not there?

18 A Well, the evidence is not there in the slides,
19 yes.

20 Q Okay. Then it says like -- it's like a heart
21 attack. If someone drops dead of a heart attack, if you
22 look at the heart at the moment, it actually looks fine,
23 because you haven't had time to have necrosis, okay?
24 Which means, I guess, that necrosis takes time to
25 develop, right?

1 A The tissue can be dead rapidly, but to show
2 changes, it does take time, that you see
3 microscopically. There is some evolution of the -- of
4 what you see in the microscope, it takes awhile for the
5 tissues to -- to manifest that change. But it -- it's
6 not long, but it does take time.

7 Q Well, it would certainly be within three or
8 four hours, right?

9 A Yes. In three or four hours, you'd start
10 seeing changes of the -- the tissue that was dead. When
11 you prepared the slides for microscopy, they would show
12 signs of having been dead for a few hours.

13 If the body were still alive -- see, the --
14 these evolution of changes occur in the context of dead
15 tissue in a live body. Otherwise, if you have dead
16 tissue in a dead body, everything sort of gets frozen in
17 place, as long as the body is preserved appropriately.
18 And then if not, you get degenerative changes that
19 relate to the body as a whole. So that's -- that's an
20 issue of preservation.

21 Q Well, I believe you've already testified that
22 the loss of blood didn't kill the child.

23 A That's correct, yes.

24 Q Would it be correct to say that what killed
25 the child was the dying of the bowel? You disagree with

1 that, too?

2 A What killed the child was the swelling of the
3 brain.

4 Q The autopsy report says what killed the child
5 was the dead gut.

6 A Well --

7 Q You disagree with that?

8 A What killed the child was the swelling of the
9 brain.

10 Q Okay. Let me ask you this: If you inject
11 medication, chemicals into the body -- into a body
12 recently after the body is dead, do those medical
13 chemicals have an effect on the brain?

14 A No. I mean, unless you're using a
15 preservative, so it will affect it from deteriorating
16 further. But if the brain is dead, you're not really
17 going to have any effect on -- I'm not quite sure
18 exactly what your question is.

19 Q So --

20 A You can -- you can always create an artifact
21 in the sense that you can inject something and cause
22 fluid accumulation or you can -- when you inject
23 fixatives, again, you kind of fix things at that point
24 when you've injected those.

25 Q What kind of things other than hemorrhage

1 would cause the brain to swell?

2 A Well, it's the -- fluid comes out of the
3 circulation and goes into the brain tissue when the
4 brain is injured. And so it's actually fluid that is in
5 the body circulation that is getting into the brain,
6 which leads to brain swelling. I mean, that's the
7 ultimate source of the fluid.

8 Q And if you put in an IV and add fluids to the
9 body, those fluids, if they're circulating, are being
10 forced to circulate, wouldn't also go into the brain?

11 A That's an interesting question. It won't go
12 into the substance of the brain, because the -- and
13 usually what happens is -- when the brain is no longer
14 functional and swollen, you can't even get perfusion.
15 The blood vessels are clamped down. And so even though
16 you're trying to run fluids into the brain -- I mean,
17 this comes up when you have somebody with a brain injury
18 that's alive and you're trying to shrink the brain with
19 some type of diuretic, you can't get the fluid to go to
20 the brain, because the pressure is so increased.

21 Q Let me -- and I apologize for interrupting
22 you --

23 A Yes.

24 Q -- but you're making point that I'd like to
25 ask you a question about.

1 A Yes. Yes, that's okay.

2 Q And the point is that you've already testified
3 on direct examination that -- that it's possible to have
4 a cardiac arrest and the brain still be functioning.

5 A No, no, no. It's seconds --

6 Q Does the brain die when the heart stops?

7 A When circulation stops, the brain stops
8 functioning within seconds.

9 See, this is why CPR is so important, to not
10 interrupt heart pumping. In fact, the new guidelines
11 for CPR is don't worry about ventilation but keep that
12 circulation. And the reason is, lacking certain -- even
13 if you --

14 Q I had it backwards, didn't I?

15 A Even if you circulate blood with little to no
16 oxygen, you'll still help keep the brain alive if you
17 can get the toxins out of there with the circulation.
18 And there's always a little bit of oxygen in the blood.
19 But if you stop circulation, it's a matter of seconds,
20 the brain starts getting injured.

21 Q Right. I had it backwards, didn't I? Because
22 you can be brain dead and still have a heartbeat.

23 A Oh, yeah, that's --

24 Q I had it backwards.

25 A Okay.

1 Q But the injection of fluids, if there's still
2 circulation going to the brain -- to the brain, that
3 would -- those fluids would also go to the brain?

4 A That's what I'm saying, is that's a difficult
5 thing. Because when the brain has suffered that type of
6 damage, and it's pressure damage -- and the brain's
7 response to injury is to have fluid accumulate in the
8 brain. And because the brain is in a fixed compartment,
9 our skull, that creates pressure, and then the pressure
10 blocks circulation.

11 So you can reestablish circulation to the rest
12 of the body by pumping on the heart, but if someone has
13 had brain injury and the brain is swollen, you don't get
14 the circulation to go to the brain. And that's one of
15 the big deficits of resuscitation procedures that --
16 only have available to them trying to get circulation by
17 pumping on the heart.

18 Q I'm sorry. I'm at that age that it seems like
19 when I lose that thought, it's just gone.

20 A I think we all suffer from that to some
21 extent, sir.

22 Q Well, let me just move to another area and
23 maybe I'll think of it later.

24 THE COURT: Y'all need some air on?

25 Q (By Mr. Thompson) Oh, I know where I was

1 going.

2 A Good.

3 Q You didn't get a chance to look at the
4 mesentery, other than in the photographs?

5 A The photographs and then the sections.

6 Q The sections?

7 A That were available, yes, yes.

8 Q Okay. Were you able to make a determination
9 of where the tears were or the scattered lacerations
10 were in the mesentery?

11 A Just -- as you said, just from the photographs
12 primarily. I mean, that photo that we've all looked
13 at --

14 Q Okay.

15 A -- shows some of those tears, yes.

16 Q And if I recall your testimony correctly, I
17 think your testimony was to the effect that the tears
18 involved small blood vessels.

19 A The -- I think what I tried to imply was that
20 they were primarily venous blood vessels.

21 Q What's venous blood vessels?

22 A Okay. I'm sorry, the circulation has three
23 major vascular components: Arteries, veins and
24 capillaries. And all tissue that gets injured will have
25 capillary damage. Those are the tiniest blood vessels.

1 Q Right.

2 A But it's the arteries that take the blood from
3 the heart and the veins back to the heart. And
4 generally the -- most vulnerable vessels, other than the
5 capillaries, are small veins. And the veins are the
6 ones that kind of get torn.

7 When you have an artery that's severed, you
8 have a lot of blood and it accumulates fairly rapidly.
9 But when you have a vein that's severed, it's a slow
10 pressure bleed. So if your injury is just capillaries
11 and veins, you will accumulate blood slowly. If your
12 injury is arteries, you will accumulate blood rapidly.

13 Q And the slow accumulation of blood, as far as
14 the volume is concerned, it would take a considerable
15 amount of time for the increased amount of volume?

16 A And not defining considerable here, but with
17 veinous and capillary injury, the period of time is much
18 longer to accumulate blood. If you've got a torn
19 artery, you accumulate blood, again, pretty fast.

20 Q Did you find any evidence of torn arteries in
21 the mesentery?

22 A Well, they -- they really didn't do a
23 dissection for that purpose. But it's by inference that
24 this is bleeding that is capillary and veinous, because
25 it's a small amount of bleeding, but over presumably a

1 couple of hours. So that would have to be
2 capillary/veinous blood, rather than arterial blood.

3 Q So it's your belief -- it's your belief, based
4 on what you've seen, that even -- even with bleeding
5 with the small blood vessels, the amount of blood that
6 had accumulated in the belly as well as the amount of
7 blood which had been absorbed in the tissue -- by the
8 way you saw the tissue absorption, didn't you?

9 A No. The tissue absorption is what we're
10 talking about with the iron deposition. I'm kind of
11 confused about what you're referring to on that. We've
12 got fresh blood, and then we've got evidence of old
13 hemorrhage that's old, remote hemorrhage.

14 Q You were aware of the fact that there was
15 freestanding blood in the belly?

16 A Oh, yes. That's the volume that we've talked
17 about. I've made reference to that several times, that
18 that was about a 20th of the child's blood volume.

19 Q Okay. And then you -- you would have to
20 account for the amount of blood that had accumulated in
21 the surrounding tissue.

22 A Oh, I see what you're saying.

23 Q The fatty issue.

24 A Infiltrated in the tissue. That's a good
25 point. And, yes, there is some blood there. That's not

1 the free blood. That's infiltrated blood. And, yes,
2 there would be some of that.

3 Q And would it take -- would it take a -- in
4 your opinion, what amount of time would it take for that
5 blood to have been able to accumulate in the tissue
6 surrounding the injury in the volume that appears to be
7 there?

8 A Well, again, the volume is low. And that
9 blood is all fresh by histology. So the amount of time,
10 again, is short.

11 There's no vital reaction to it. There's no
12 inflammatory reaction. There's no breakdown of the
13 blood products, except for that area that had the
14 evidence of the old hemorrhage.

15 You know, we've got a superimposed old
16 hemorrhage area of some type of traumatic event in the
17 past and then this -- this broad area of -- of new fresh
18 hemorrhage of just a few hours' duration.

19 Q Okay. And we are at least in agreement that
20 your assessment of -- of these things differs
21 significantly -- significantly from that of both
22 Dr. Pustilnik and Dr. Quinton?

23 A So you're saying we agree to disagree?

24 Q We agree that we disagree.

25 A And to comment on that for pediatrics and

1 evaluating pediatric issues, functionality becomes a
2 very important concept with timing, and so it's not just
3 the findings of whether there's been tissue reaction to
4 the blood that's there. But it's the fact that a child
5 who is functional and not manifesting signs of
6 irritation -- not in a state of depression or -- or near
7 sleep or something like that -- that functionality is a
8 reflection of timing.

9 So that when someone gives a range based on
10 the presence or absence of blood, that range may have
11 some validity in a theoretical sense. But then when you
12 have information about functionality on the part of the
13 child, that helps you narrow down that range. And often
14 in pediatrics, you then rely on the functionality
15 information far more than you do on the theoretical
16 range of how long it takes blood to break down and stuff
17 like that.

18 And that's where I would say the business
19 saying up to a day is not appropriate, because we have,
20 by the statements already made on the record, evidence
21 that the child was functional, in a very good state,
22 very close to the time that the child was in an
23 irretrievable condition.

24 Q So your position would be, if I'm correct,
25 that the story that people tell you -- the information

1 that you get is more significant to you than the
2 microscopic finding and the examination of the body? Is
3 that what you're saying?

4 A There's some element of -- of truth to how you
5 just said it, but that's what I tried to show in that
6 chart, is that if you take the findings, you then take
7 the historical context of those findings, which is the
8 story, and then you come to some conclusion. It's kind
9 of a three-step process. So the findings, the story
10 behind the findings, and then you try to put them
11 together.

12 Now, in this case, the story that we
13 apparently are getting from your client is that this
14 child was fully functional, in fact, was eating and
15 active and so on and so forth.

16 Q Let me correct you -- that's the story you got
17 from the State.

18 A Oh, okay.

19 MR. BINGHAM: That -- well, that's the
20 story that came from the -- from the CD's.

21 THE COURT: His -- the statement of the
22 defendant is in evidence. Maybe just refer to the
23 statement of the defendant in evidence.

24 Q (By Mr. Thompson) Well, the statement from my
25 client is and the statement from the child's mother is

1 that the day before the child died, the child was not
2 eating normally. Okay?

3 A Okay.

4 Q Subtle changes in the child -- as a matter of
5 fact, would you expect a child with a wound --

6 MR. BINGHAM: Judge, my objection is
7 going to be, there is no statement like that from the
8 defendant anywhere in those audios -- I mean, those
9 video statements or audios --

10 THE COURT: Isn't there a transcript --

11 MR. THOMPSON: I thought I said the
12 child's mother.

13 MR. BINGHAM: Well, you said the mother
14 and the father.

15 THE COURT: You said the defendant and
16 then you went to the mother, and then you said "as a
17 matter of the fact" before he had a chance to answer the
18 first one.

19 Q (By Mr. Thompson) Well, let me clear up.

20 A Sure.

21 Q We have testimony in the record from the
22 child's mother, okay? We have testimony in the record
23 from Mr. Miller, by way of his recorded statement, that
24 on the morning before the child died, okay -- his
25 testimony which corroborates her testimony is that they

1 went to -- they went out to eat around twelve, one
2 o'clock, somewhere in that timeframe.

3 A Okay.

4 Q We have testimony from the child's mother and
5 the child's grandmother, Linda Franklin, that the
6 child -- and the child's father, Kelvin Arterberry, that
7 the child normally is a very hearty eater. As a matter
8 of fact, I believe Mr. Kelvin Arterberry's testimony was
9 that he liked everything, okay?

10 A Okay.

11 Q Particularly fond of honeybuns and Cheetos and
12 stuff like that.

13 A And so I'm clear, you're talking about the day
14 before the child's death?

15 Q Yeah. I'm just giving you a little
16 background. So this child is a healthy eater, for this
17 hypothetical. This child was a healthy eater.

18 A Okay.

19 Q The testimony of the child's mother, which
20 corroborates the recorded statement of my client, was
21 that on the morning -- on the morning before the child
22 died, they went out to eat, that the child -- they
23 ordered, I believe, french fries, mashed potatoes, she
24 gave the child some of her steak. Normally he would eat
25 that stuff. But on this particular morning, he didn't

1 eat.

2 A Okay.

3 Q No appetite to eat, okay? Evidence that he
4 was thirsty -- by the way, in this kind of injury, would
5 you expect a person or a child to be thirsty?

6 A Yes, you may have thirst, but you won't have a
7 good ability to tolerate input of any sort, oral input,
8 either drinks or solid.

9 Q Okay. So you --

10 A Once you've had these injuries, you would not
11 tolerate food.

12 Q So it's your -- it's your conclusion that --
13 that at the point of injury, at the point of injury --

14 A Yes.

15 Q -- you lose the ability to tolerate food?

16 A Right. Because what characterizes this
17 thing -- and you can see by the picture we've been
18 looking at. But what characterized this as an extreme
19 irritation of the organs, and specifically the
20 intestines in the abdomen by the blood that is on the
21 surface -- and so there is not tolerance of oral input
22 at all, solid or liquid, and it's that irritation issue.

23 And this is why what you're saying -- that
24 would have some relevance from a historical point of
25 view, but then you have the next day and then you have

1 stories that the child was eating okay and, in fact, in
2 that period of time, under the care of your client, we
3 have the story of the child eating and drinking okay.

4 Q Well, I -- and I can certainly understand how
5 you come to the conclusions you come to, if it's your
6 belief -- if it's your belief, okay, that this kind of
7 injury results in immediate inability to consume food.

8 A Yes. The type of injury that leaves tears in
9 the belly and free blood in the belly and blood in -- in
10 the mesentery is the kind of injury that will interfere
11 with any type of eating and activities around eating.

12 Q So if that's the case, where Dr. Quinton
13 testifies before the grand jury, on that page in that
14 transcript that I showed you, that I have seen kids -- I
15 have seen some kids live for days, how would that be
16 possible if at the point of injury you're no longer
17 capable of consuming food or liquid?

18 A They -- they live in a state of dwindles. And
19 what happens in these cases -- and I agree with the
20 general observation that you've -- that kids that have
21 had abdominal trauma with injury and bleeding in the
22 abdomen can survive for a long period of time. It's
23 unusual to go more than a day or so, but yes, that can
24 happen.

25 But they survive in a state of dwindling.

1 They're not eating. They're not basically drinking.
2 They're pining away. They're -- they're in a state of
3 suspension. They're slowly going out of consciousness.
4 And one of the reasons when an event like that
5 occurs with this type of trauma that causes belly
6 injury, the acute pain from the trauma has worn off, but
7 now you have this -- the dwindles that come from not
8 being able -- not having activity, it hurts to move,
9 it -- it's a slow death. It's a dwindling death.

10 And, yes, days might apply, but these are
11 someone who is hidden away in a bedroom so that no one
12 sees them up to the point that they become unconscious.

13 Q It would be somebody who is hidden away in a
14 bedroom, wouldn't be children who might be walking away
15 in a flea market or engaging in other activity where
16 people would see them?

17 A That's exactly correct, yes.

18 Q So if -- if a board certified pathologist
19 testified to that scenario, you would certainly disagree
20 with that?

21 A With belly trauma that resulted in blood and
22 tears, I would absolutely disagree with that, and that's
23 why you need pediatric input into this, both from
24 pediatric pathology and general pediatrics in terms of
25 understanding functionality of kids.

1 Q By the way, Dr. Wilson --

2 A Yes, sir.

3 Q -- how many, in your practice, how many
4 children have you -- in your practice, your pediatric
5 practice, how many children have you treated with
6 mesentery tears?

7 A I would say that I've really not treated
8 directly children with mesenteric tears.

9 If I may answer -- answer that question, the
10 part of pediatrics that I practice now is pediatric
11 emergency medicine in an outpatient clinic setting. And
12 if someone I see has signs of abdominal trauma, I send
13 them to an emergency room in a hospital to be admitted.
14 So I would not participate in treating someone with
15 mesenteric tears.

16 Q And during your surgical residency, how
17 many -- how many people have you operated on with these
18 kind of wounds to the belly?

19 A Okay. Now, I didn't do a surgical residency,
20 but I -- I didn't do much in the way of surgical --
21 direct surgical experience. In other words, I rotated
22 in my medical school training, I rotated through surgery
23 rotation, but I didn't -- I have not and did not
24 practice pediatric surgery.

25 Q Well, how many children have you referred

1 to -- have you looked at and treated and referred to
2 surgeons or other doctors because they had these kind of
3 wounds and you suspected that they may have been
4 mesentery tears? How many of those children have you
5 seen?

6 A I would say very few where I suspected
7 mesenteric tears. I've certainly had children that have
8 had an acute abdomen, and I've referred them to surgeons
9 at the emergency room for evaluation of acute abdomen,
10 such as acute appendicitis and other things. The issue
11 with acute abdomen in children is you don't know what it
12 is sometimes until you get in there.

13 Now, with imaging studies that are available
14 today, you can have better knowledge of whether you're
15 dealing with a ruptured appendix or a twisted bowel or
16 some other type of structural emergency. But the main
17 thing that's incumbent upon the practicing pediatrician
18 and someone in a pediatric clinic is recognizing that
19 you've got an acute abdomen and it needs surgical
20 attention and you need to get them to the right place,
21 which is an emergency room where they have access to
22 emergency surgery.

23 Q Okay. And, again, that's -- that's a lot of
24 words. But the bottom line is that you haven't seen
25 very many children with this kind of condition in your

1 practice?

2 A Not living children. I've seen a lot of
3 children with problems of acute abdomen that I refer on,
4 but it's very rare to have the acute abdomen due to
5 multiple blunt force trauma as in this case.

6 Q Can you tell us when was the last time you --
7 you diagnosed a mesentery injury --

8 A I --

9 Q -- in your pediatric practice?

10 A Not in my -- you don't diagnose that in the
11 pediatric practice. You diagnose that by surgery or by,
12 unfortunately, autopsy.

13 Q Okay. And, of course, you don't -- you don't
14 do surgery?

15 A I don't do surgery, but I do a lot of
16 autopsies, yes.

17 Q You said initially that you moonlight as a
18 pediatrician.

19 A In a pediatric emergency clinic, yes, that's
20 correct.

21 Q Where is that?

22 A Well, it's a few blocks from the hospital.
23 It's called the West Side Pediatric Night Clinic.

24 Q Okay.

25 A And on Friday, Saturday and Sunday nights, I

1 work from 6:00 to 11:00 or midnight, and in the
2 evenings, I can see anywhere from 30 to 40 kids.

3 Q Is that like a free clinic or something, where
4 you're volunteering your time?

5 A No, no. I get paid for that. And it's 75
6 bucks if you don't have coverage. Most of our patients
7 are Medicaid patients. But we have a -- a good number
8 of private pay patients. But in El Paso, the majority
9 of children are under Medicaid.

10 Q Okay. Early on in your testimony, when you
11 began talking to Mr. Bingham, about the fact that you
12 don't charge any fees, I believe you said that you don't
13 charge any fees other than expenses for this kind of
14 testimony, and you're willing to review documents and
15 render opinions in these kind of cases for your own
16 perspective.

17 What is that perspective?

18 A The -- I'm not -- for my own perspective, I'm
19 not quite sure.

20 Q I may have written it down wrong. But I
21 thought that's what you said, for your own perspective.

22 A I -- I'm not quite sure. I don't remember
23 saying it that way. You're asking me what?

24 Q Let me ask you a different -- what is the
25 reason why you do this for free? Are you writing a

1 book?

2 A No.

3 Q You're not working on a book?

4 A I mean, I -- you kind of got me there. But I
5 guess I have a sense of payback. I mean, I was -- I was
6 sent to medical school and graduate school under public
7 monies. And so, in other words, the -- collectively,
8 the society -- the U. S. society paid for me to become a
9 doctor. And my way of payback is to try to help the
10 legal system with pediatric medical problems.

11 Q Uh-huh.

12 A I mean, I was funded for seven years in
13 graduate school and medical school, both tuition and
14 living expenses, to be able to acquire my education.
15 And that --

16 Q So you're not gathering materials to do
17 another book or another course study or any anything
18 like that?

19 A No. I mean, I've not written a book. I
20 helped write that chapter, as we talked about, but no,
21 no, this is --

22 Q And you're not working on anything presently?

23 A No. I moonlight to -- to support my -- my
24 family. You know, I don't make the -- the -- I need the
25 extra money to be able to cover my living costs.

1 Q So when you -- when you help out doing --
2 doing pediatric autopsies, when you help the -- the
3 board certified forensic pathologist doing the pediatric
4 autopsies and stuff like that, you don't get paid for
5 that?

6 A No, I don't get paid for that.

7 Q All of this is volunteer?

8 A I'm on the volunteer faculty of the medical
9 school.

10 Q So --

11 A But I do moonlight in an emergency clinic to
12 earn extra money, and it keeps my pediatric skills
13 sharp. I mean, that helps me stay current with
14 pediatric -- pediatric practice.

15 Q And when you just associate yourself with the
16 medical examiner's office, sort of helping around with
17 these autopsies and stuff that you do --

18 A Yes.

19 Q -- does that -- does that -- because you're
20 not board certified or you're not a forensic
21 pathologist, does that mean that you don't have to take
22 continuing education courses with respect to this area?

23 A Well, I -- I do take courses and, in fact, I
24 teach courses. On a regular basis, I'm a speaker at
25 national conferences on investigating pediatric death

1 and child abuse death and things like that.

2 I do that all the time.

3 Q But my question is about pathology. The -- do
4 you take continuing educational courses with respect to
5 doing autopsies?

6 (Reported by Steve R. Awbrey, CSR:)

7 A No, I wouldn't say I take -- I participate in
8 conferences which are continuing education conferences,
9 and I present at those conferences, and you know, I also
10 attend. When I'm there, I listen to what the other
11 people are doing, but I don't -- the advantage for me if
12 I'm a speaker, I don't have to pay for the conference,
13 so...

14 Q What's the last conference you spoke at?

15 A Oh, I mean, I speak at conferences all the
16 time.

17 Q What's the last one you spoke at?

18 A I'm trying to think of -- I did grand rounds
19 in the last month or so at the hospital where I am, I
20 mean, I really -- it's hard for me to keep track of
21 these -- I do a lot, sir, and I just don't keep track of
22 them well.

23 Q Right.

24 THE COURT: Let's take about a 10-minute
25 recess for the jury.

1 All rise for the jury.

2 (The jury left the courtroom.)

3 THE COURT: We're back on the record in
4 Cause Number 241-1251-08. The State is present. The
5 defense is present. The defendant is before the Court.
6 The witness is on the witness stand.

7 The jury is on their way back into the
8 courtroom.

9 (The jury entered the courtroom.)

10 THE COURT: Be seated, Ladies and
11 Gentlemen.

12 Mr. Thompson, whenever you're ready,
13 Mr. Thompson.

14 MR. THOMPSON: Thank you, Your Honor.

15 THE COURT: Yes, sir.

16 Q (By Mr. Thompson) Counsel spoke with you on
17 direct about this notion of the reliability of core body
18 temperatures as it relates to timing the death of an
19 individual. You remember that?

20 A Yes.

21 Q And I believe that it was your testimony that
22 a rectal temperature was a core body temperature, first
23 of all?

24 A Yes.

25 Q And that it was -- and that the rectal

1 temperature would be reliable?

2 A Well, it would be useful, yes.

3 Q Okay.

4 A More reliable than skin temperature, yeah.

5 Q What's the difference between reliable and
6 useful?

7 A Semantics, maybe. I shouldn't have made that
8 distinction.

9 Reliable sounded like you wanted it to be for
10 certainty and useful meaning that it helps you with a
11 range. Body temperatures are -- if you really want a
12 core body temperature, you literally have to go into the
13 core of the body, which would be into the central part
14 of the abdomen or some place like that deep in the body,
15 and you know, that's not a practical thing to be done on
16 the scene.

17 And then the measurement is a real thing, but
18 its significance can have variable meaning, because
19 sometimes when there's brain injury in someone who is in
20 the process of dieing, that brain injury itself whether
21 it's due to trauma or lack of oxygen can cause abnormal
22 regulation of body temperature.

23 And with that abnormal regulation, the
24 temperature can actually go up or down more than just by
25 heat loss. In other words, by simple heat loss. So if

1 the person is still alive and has abnormal control of
2 body temperature because of brain injury, again, either
3 by trauma or lack of oxygen, the body temperature can be
4 variable and not be the timing thermostat that you want
5 it to be.

6 The point that we're talking about body
7 temperature is to have some idea of how long someone has
8 been dead, but if that person developed a high body
9 temperature before they died because their control
10 systems were messed up, it would make you think that the
11 duration in time was shorter. Or if they had a low body
12 temperature before they actually died, you would think
13 the duration of time before death was longer.

14 So what I'm trying to say that while body
15 temperature is one piece of information that one tries
16 to use, it has a lot of potential variability there in
17 terms of its meaning.

18 Q So it's not very reliable?

19 A Well, it's reliable for a range, but it's
20 not -- you can't say someone was dead for three hours
21 and 20 minutes. But the best way, as with other things
22 to time events is by direct observations. The same
23 applies to the business of functionality for when a
24 child is injured.

25 The best way to know whether a child is

1 injured is when did the child last behave normally and
2 when did the child behave abnormally. And abnormal in
3 the way that reflects the effect of the injury. That's
4 a far more reliable way of knowing when the injury
5 occurred than by trying to date it like by bruises or
6 other things.

7 Q Okay. And I understand the analogy that
8 you're drawing, but the question is --

9 A Yes, sir.

10 Q -- with respect to the reliability of taking a
11 rectal temperature that indicates a body temperature of
12 91.1, how reliable is that?

13 A It's reliable to some extent, but it also
14 implies technique. If you don't wait long enough, the
15 thermometer doesn't register accurately. It depends on
16 whether it's an electronic thermometer or an old
17 fashioned mercury thermometer. There's a lot things
18 that go into that.

19 But be that all said, a temperature of that
20 level, all things being equal, would indicate that the
21 person has been either dead or in a dysfunctional state
22 prior to death for several hours to have a temperature
23 that low, below normal body temperature.

24 Q Okay. And of course that assumes that there
25 was a normal body temperature at the point of death?

1 A Right. And that's -- I tried to say that. If
2 you have brain injury from lack of oxygen, if you have
3 brain injury and the brain is swollen, the regulation of
4 the body temperature will also often can be disturbed
5 again, either too hot or too cold.

6 In other words, the brain doesn't regulate
7 temperature right as it should.

8 Q What would be some factors that would increase
9 body temperature so that the body would be too hot at
10 the time of death?

11 A Brain injury. Some response to brain injury
12 you become hypermetabolic. The temperature actually
13 goes up. That's why I'm saying -- that would throw off
14 an interpretation of whatever the temperature is because
15 of the error introduced in the temperature not being
16 normal at the time the child died.

17 Q What would be a factor that could cause the
18 body temperature to be lower than 98.6 at the time of
19 death?

20 A That the child was in a state of sort of
21 lingering prolonged dieing and in that state of
22 prolonged dieing, there was heat loss without good heat
23 generation, so that the body temperature is actually
24 lower before the child's heart stops beating.

25 Q Would it be fair to say that without knowing

1 what the body temperature was at the time that the child
2 actually died, okay. That you don't make an accurate
3 assessment with respect to body temperature from the
4 rectal -- from the rectal thermometer?

5 A Well -- and here is a range of accuracy. You
6 can make a judgment that there's been several hours time
7 pass, all things being equal, and all things being equal
8 on average with room temperature situations and a young
9 child's body losing about on average two degrees an
10 hour, with a temperature of 91, I think it was, one
11 could say that that might be on the range of three or
12 four hours, but it's not -- it's a range and you know it
13 could be shorter. But during that period of time, the
14 child's body has lost heat.

15 Again, all things being equal, meaning that
16 the child was not in a lingering state of dieing for a
17 while so that the time of death would be closer to when
18 the child had that low body temperature, but was at a
19 state of 97, 96 for a period of time.

20 Q Would the body temperature be so -- would the
21 body temperature be unreliable to a point that it could
22 lead somebody to a false conclusion with respect to the
23 time of death?

24 A Theoretically, yes, it could especially if it
25 was hyper -- if the patient were hyperthermic from some

1 type of brain affect of edema or trauma. I'm not saying
2 this child had brain trauma. This child had brain
3 edema, but hyperthermia can occur and that would in a
4 sense -- the word is fictitious, but in a fake way, fake
5 for interpretation, raise the body temperature so that
6 it would seem that the duration of time that the child
7 was dead was shorter than it really was.

8 Q Okay. And isn't it a fact that even in the
9 article that you assisted in having published, you-all
10 stated in that publication on page 474 that estimating
11 the time of death from body temperature also is subject
12 to sufficient error, that it may lead investigators
13 astray and one could be conservative in using such
14 measurements?

15 A I couldn't have said it better, in fact, I
16 did. I agree with that, yes.

17 Q Which is very consistent what you just said?

18 A Yes, that's correct.

19 Q You cannot make a definitive determination of
20 the time of death from body temperature?

21 A Yes, that's correct.

22 Q Now, with respect to the so-called range that
23 you're talking about, when you try to fix the time of
24 death within a range, what you're really doing is --
25 you're estimating, based on what your findings are and

1 what the story is that you've been told about the time
2 of death?

3 A Yes and yes. And this is why the best way to
4 make a judgment about when someone has died is a direct
5 observation or reliable observation on functionality of
6 someone.

7 In other words, was that person walking,
8 talking and breathing at a certain point in time, then
9 you know they weren't dead at that point in time. If
10 you had a good reliable statement, that trumps
11 everything else.

12 Q And, of course, the story -- the reliability
13 of the story, if you're going to factor in the story --
14 I mean, the reliability of the conclusion that you make
15 if you're going to factor in the story, depends upon the
16 reliability of the story, doesn't it?

17 A Yes.

18 Q Kind of like computer science, you put junk
19 in, you're going to get junk out?

20 A Yes. One needs to take into account stories
21 and put them in the picture, but you also need to in a
22 sense have some way to independently verify the stories,
23 too.

24 Q In looking at the photographs of the abdominal
25 bruising, I believe your statement was that the

1 dark-colored bruising was a reflection of the liver
2 after the body had been dead for a period of time?

3 A Yes, I believe so, sir, yes -- that was my
4 statement, and yes, I believe that to be the case, yes.

5 MR. THOMPSON: May I approach,
6 Your Honor?

7 THE COURT: Yes, you may.

8 Q (By Mr. Thompson) Help me, if you would to
9 clarify something that's racing in my mind. I won't be
10 able to sleep tonight?

11 A I don't want that.

12 Q Where is the liver in this photo?

13 A Here is the liver. This is the liver.

14 Q This is the liver here?

15 A Yes.

16 Q And I believe you said there was the heart up
17 here?

18 A That's the heart up there, yes.

19 Q Now, when you get that kind of purple
20 coloration, is there something that like seeps down from
21 the liver that causes that purplish coloration across
22 the abdomen?

23 A No, usually it's the liver when it's
24 congested. The other thing that it can be, is the
25 presence of the blood itself that's there. I mean, the

1 liver is a very bloody organ.

2 Q And the reason I'm asking that question?

3 A Yes.

4 Q Is because the liver is up here, and I believe
5 you've already identified this as the breastplate
6 removed so that you're exposing the liver. Up here and
7 you can see from the picture of the child, the ribcage
8 area, which is here. The same as this on this picture,
9 the liver would be -- if I'm -- you know, I'm not a
10 doctor, but I mean, this would be kind of underneath
11 this ribcage here, right?

12 A Right.

13 Q A considerable distance from this
14 purple-colored bruising down here on the abdomen. So
15 does something from the liver just kind of drifts down
16 there and turn it purple?

17 A That's a very good point you're making.

18 There's two things here. One is this appears
19 to have pulled up to be able to better demonstrate this
20 area of mesenteric hemorrhage. That's part of what may
21 be going on. The other thing that the bruising that's
22 seen -- not the bruising -- the discoloration that's
23 seen, may not necessarily be the liver, it may actually
24 be seeing this color of this part of the blood
25 accumulation.

1 I cannot tell directly from the photograph if
2 this has been pulled up. This is a bit higher than one
3 usually sees in the diagram. The diagram kind of comes
4 across like this, but you're making a good point, and
5 usually you see the liver extend. It goes across the
6 midline and to the other side. You usually see the edge
7 of the liver over this whole expanse.

8 But what I've got here is this hemorrhagic
9 mass, which is the mesentery, and I cannot tell from
10 this photograph if this has been kind of opened like a
11 book and folded back, which would then have the liver
12 still be part -- part of the liver still be behind this
13 or if what we're saying is actually hemorrhage into the
14 mesenteric mass.

15 Q Well, if we have testimony that the
16 intestines, whatever that is large or small intestines,
17 has been folded back?

18 A So they have been folded back?

19 Q Yes.

20 A Okay.

21 Q But nothing about the liver -- you're saying
22 the liver would be pushed up?

23 A It would be pushed up, but the part of the
24 liver that goes over here is maybe covered by this, but
25 it may well be that what that discoloration is, is

1 actually the blood that was in this mass of mesenteric
2 tissue itself.

3 Q Or it could be a bruise?

4 A It's a very unusual bruise.

5 Q But it could be a bruise?

6 A Well, it could be. That's the appearance more
7 of the translucency through the skin.

8 Q Have you heard the term, back to front before
9 in your medical experience or front to back, either way?

10 A I can't respond to that in context, without a
11 context, what do you mean?

12 Q An experience where someone hits you on the
13 front and you bruise on the back, is that possible?

14 A Now, are you talking about coup-contracoup
15 type of concept which occurs in the brain.

16 Q I call it back to front.

17 A Generally, that's a concept for the brain
18 where you have a fixed container, the skull, and if you
19 get hit on one side of the head, it sets the brain
20 moving inside the skull, and then you get a bruise on
21 the surface of the brain on the back side of the brain.

22 Q But with respect to this part of the upper
23 body cavity, you do have a contained area, don't you?

24 A Well, actually not. It's a very loose area.

25 Q It's contained within the confines of the rib

1 and the sternum?

2 A Well, the chest is more -- the belly is not --
3 I think we've talked about that some. The fact that
4 stuff moves around in the belly and that's why it's
5 harder to have impact injury cause problems except where
6 you have the midline and you compress it against the
7 backbone.

8 Q Actually, you've got a contained area in the
9 upper part of your body which is protected by the
10 ribcage in the sternum; isn't that correct?

11 A Well, that's the chest that you're describing.

12 Q And the rib cage does not -- is not just
13 around here, it actually goes all the way around to the
14 back and extends downward, doesn't it?

15 A That's correct.

16 Q Sure.

17 So that's an enclosed area where you could
18 get a -- you could conceivably get a blow in the front
19 that produces a wound or bruise in the back?

20 A Well, it's not quite the same thing as happens
21 with, again, the coup-contracoup, which is exactly what
22 you're saying. The blow, counter blow business.

23 What you're describing is more that if you
24 have an impact say on the front of the body and the back
25 of the body is resting on something or hits something,

1 then there could be a transmission of the injury that
2 way. But it depends on external-type of relationships.
3 The internal one in the brain is where the brain is
4 captive inside the skull and then you get this -- the
5 brain sort of bounces from the front to the back in the
6 skull, and it has nothing to do with the external
7 surfaces that are being hit. It has to do with the
8 internal arrangement.

9 Q What if you've got -- you said it depends on
10 the kind of surface that you're on?

11 A That's right.

12 Q What if you've got somebody laying on a hard
13 concrete surface?

14 A Yes.

15 Q And you've got somebody pounding on their
16 chest trying to resuscitate, could you get a bruise on
17 your back.

18 A Oh, yes, absolutely that can happen -- I'm
19 sorry. I wasn't understanding exactly what you were
20 asking.

21 Q And that's sort of what all of these scenarios
22 are about, a thorough understanding of what's going on?

23 A Yes.

24 Q I don't recall if I asked you this question or
25 not, but could you tell us the number of autopsies

1 you've actually participated in where you have seen
2 these kinds of mesentery tears?

3 A Where I've actually done the autopsy with
4 mesentery tears?

5 Q Yes, sir.

6 A That would be -- less than five where I've
7 actually done the autopsy with mesentery tears. In
8 reviewing autopsies with mesentery tears, it would be
9 significantly more than that.

10 Q By reviewing, you mean looking at the pictures
11 and the photographs?

12 A That's right, yes.

13 Q When you testified earlier that the bleeding
14 from the mesentery had not been there long enough to
15 have a secondary reaction, what did you mean by that?

16 A That there are a series of changes that occur
17 in response to blood in the belly, and ultimately
18 leading to the red cells breaking down and iron
19 accumulation, and we've talked about the iron in one of
20 the pictures from the old event of hemorrhage in the
21 belly. But part of the reaction that occurs to blood in
22 the belly is you start getting secondary clot formation
23 with what's known as fibrin deposition and that's a
24 protein-type of material that accumulates and you start
25 getting cells, inflammatory cells that come and react to

1 the red cells being in the wrong place at the wrong
2 time. And there's none of that sort of secondary
3 reaction that's present.

4 Q That you saw?

5 A That I saw in the pictures, yes -- the slides.

6 Q But if Dr. Quinton testified in his Grand Jury
7 that he saw signs of inflammation, he would have been
8 mistaken about that?

9 A No, I don't want to say he would be mistaken,
10 it's just that -- one has to be careful when you say
11 inflammation to make sure that it's not just the white
12 cells that come with the red cells when you have
13 bleeding. I mean "inflammation" refers to white cells
14 in the blood, and that it's a true vital reaction to the
15 presence of blood, which is in that location is a
16 foreign substance. The blood shouldn't be there and the
17 body starts responding to that.

18 But at least in the slides that were taken at
19 autopsy, that wasn't there. I mean, there's the old --
20 there's the old, that spot of old degenerative material
21 and iron. That's the one I took a picture of, but
22 that's remote, that's not connected with the event of
23 the child dying.

24 Q We'll deal with that in a minute --

25 MR. BINGHAM: Was there a page reference.

1 I don't see the inflammation in the Grand Jury --

2 MR. THOMPSON: It was a hypothetical
3 question. It was a hypothetical question.

4 THE COURT: Mr. Thompson, you're not
5 referring to what the doctor testified at Grand Jury?

6 MR. THOMPSON: I'm referring
7 hypothetically if he saw signs, hypothetically?

8 A Okay.

9 Q (By Mr. Thompson) If he saw signs of
10 inflammation at the time that he did the autopsy and,
11 hypothetically, if he were to testify to that, it would
12 be your opinion that he had made a mistake?

13 MR. BINGHAM: I'm going to object to the
14 form of the question.

15 THE COURT: I'm going to sustain it on
16 form. You're asking him a question about
17 hypothetically. It's not phrased in terms of whether or
18 not he actually testified to that.

19 MR. THOMPSON: If he testified
20 hypothetically, Judge.

21 THE COURT: All right. The objection is
22 sustained. We'll leave it at that.

23 Q (By Mr. Thompson) But then on the other hand
24 you have read the Grand Jury testimony from Dr. Quinton?

25 A Yes, sir.

1 Q And you are familiar with the statement where
2 he says on page 46, so I say these injuries are within a
3 day. I don't think there's more than that because there
4 would be a lot more organizational changes than
5 inflammation.

6 So he didn't see anything but the
7 inflammation, but then if he said he saw inflammation,
8 in your opinion, that would be incorrect?

9 A And you're correct in what you're saying by
10 what you just read that that's implying that he saw
11 early inflammatory response to the blood that's there.
12 I did not appreciate that in the slides. This is not a
13 gross observation. This is a microscopic observation.
14 I did not appreciate that there was an inflammatory
15 response to the blood. That it was fresh blood with
16 basically little to no reaction to the blood.

17 Q So could there have been something there that
18 you didn't see?

19 A That's always possible, yes.

20 Q Isn't it true, Dr. Wilson, that the iron
21 produced in the blood cells as the result of an
22 injury -- I'm sorry. Strike that -- let me ask you in
23 different way.

24 The iron that you see in the blood cells as a
25 result of the injury merely provides you a description

1 of the fact that the injury has some age?

2 A Let me just clarify a little bit.

3 There is always iron in blood cells, but it
4 becomes of a form that appears different than in blood
5 cells that have degenerated.

6 Q Right.

7 A And when you appreciate that degenerative form
8 of iron, then you know that the blood cells have been
9 there and deteriorated over a period of time, so the
10 basic answer to your question is correct.

11 Q And what you can tell from that is the fact
12 that you've got an aged injury, isn't that true?

13 A That the blood has been there for a period of
14 time. When you first started seeing that form of iron
15 that you can now recognize in the microscope after about
16 a day, and then that is correct.

17 Q So it would take about 24 hours for that to
18 manifest itself, so that it can be identified?

19 A Right. For the first signs of seeing iron,
20 that's correct. The iron is there -- I'm sorry, sir.
21 The iron is there. It just becomes transformed into a
22 product that you can now see under the microscope.

23 Q There's nothing about being able to see that
24 on a slide that tells you anything about a fresh injury?

25 A About what?

1 Q A fresh injury?

2 A Freshness is related to the integrity of the
3 red cells and the lack of seeing this degenerated form
4 of iron.

5 Q And does it make a difference what part of the
6 body the cells come from?

7 A Okay.

8 Q Do the cells migrate throughout the body?

9 A What cells are you talking about?

10 Q The cells that produce this discernible iron
11 contact?

12 A Those are our red blood cells, yes, that's
13 what keeps us alive. They carry oxygen, and as you
14 know, they migrate everywhere in the body through the
15 bloodstream.

16 Q If I've got an injury in my leg, and I've got
17 a fracture in my leg. Okay. At some point, you would
18 expect -- you would expect to see those kind of blood
19 cells even if you took blood from my arm?

20 A That's a good question.

21 No, what we're talking about are the cells
22 that go out of the blood vascular system, so if you have
23 fracture in your leg, you've also torn blood vessels,
24 the cells would leak out into the area of the fracture.
25 They no longer circulate. They degenerate the iron and

1 then undergoes it's transformation in the tissue where
2 the injury is.

3 So in a sense, they actually act as a marker
4 of an injury site, but no, you wouldn't see that
5 elsewhere because the other red cells that aren't
6 leaking out there continue to circulate, and they don't
7 degenerate.

8 Q And the vascular system is a closed system
9 unless there's an open wound in one of the blood
10 vessels, which allows the blood to leak out?

11 A That's correct, yes.

12 Q So the cells which depict the injury are going
13 to be in the area of the injury.

14 A That is correct, sir, yes.

15 Q So if I've got a hairline fracture of my, for
16 lack of a better word, my leg?

17 A Tibia.

18 Q Let's just say leg?

19 A Yes.

20 Q And tomorrow on the weekend, I break it again,
21 okay. I break it in the same area?

22 A Yes, yes.

23 Q Are you going to see those same -- that same
24 accumulation of blood cells in that area?

25 A You will see a combination as we have in this

1 case. I mean, you're describing this very well.

2 You will see a combination of cells from an
3 older injury or in this case the iron present from an
4 older injury, and then you will also see fresh red cells
5 that are from the new injury, so you will have that dual
6 affect from an old injury and a new injury.

7 Q But after a period of 24 hours, you wouldn't
8 be able to make that distinction?

9 A Well, but the changes are gradual, so you
10 would still see fresh red blood cells. It's just that
11 the numbers are slowly going down as they're
12 deteriorating and the products are being released, so
13 it's not hard and fast at 24 hours, but the concept is
14 right the way you're seeing it. There's a gradual
15 change from fresh appearing red cells to degenerated red
16 cells to iron accumulation.

17 Q So by looking at those blood cells, a forensic
18 pathologist could pretty accurately within a range date
19 that injury?

20 A Well, but see the problem comes when you've
21 got different injuries at different times at the same
22 place, that's where you get into trouble.

23 Q What is it about that, that would allow you to
24 see the difference that wouldn't allow him to see the
25 difference -- either the blood cells you can identify

1 the iron content in the blood cells or you can't?

2 A Okay. It -- actually the iron that you see is
3 no longer in the blood cells. It's leaked out of the
4 blood cells and undergone this transformation, so that
5 it now appears as a pigment in the tissue, and so you go
6 from having intact red cells with no pigment in the
7 tissues to no intact red cells and pigment in the
8 tissue. The one that I took a photograph of is pigment
9 in the tissue with no intact red cells. That's showing
10 a site of old prior injury, not fresh injury.

11 Q What part of the mesentery did you examine
12 that allowed you to determine that there were -- that
13 the injury was fresh, where there's no iron in the
14 tissue?

15 A Well, it was the part that they took in the
16 slide. I mean, they describe as we see on the
17 photograph, areas of mesenteric hemorrhage, and they
18 take a sample on the slide and you see in the majority
19 of that area, it's all fresh blood. And then there is
20 one area on one of the slides where there's this old
21 injury that's there. But that's separate from all of
22 the fresh injury that's gone on.

23 Q So if there's testimony in the record that all
24 of these injuries occurred at about the same time in
25 your opinion, that would be incorrect?

1 A That would be incorrect related to that --

2 MR. BINGHAM: I'm going to object to the
3 form -- which -- I think --

4 MR. THOMPSON: It's a hypothetical
5 question.

6 MR. BINGHAM: I think it's unfair to say
7 that when we're talking about multiple injuries to a
8 victim abdominally and then talk about an old rib
9 fracture and new ones. Are we talking about the rib
10 fractures or the multiple injuries.

11 THE COURT: Can you separate those?

12 Q (By Mr. Thompson) Do you understand what I'm
13 talking about?

14 A I do understand your question.

15 THE COURT: Separate out the fractures in
16 terms of the tract --

17 Q (By Mr. Thompson) We're talking about the
18 mesentery?

19 A The soft-tissue injury in the mesentery, and
20 there's a prominent area both by photograph and in the
21 slides of fresh injury with bleeding of just a few hours
22 duration, and then there's one area on one of the
23 slides, really separate from all of this fresh bleeding
24 that doesn't have any intact red cells, but has this
25 iron accumulation, and that says that that's a site that

1 had injury in the past in which now you have the marker
2 of residual iron from some event in the past.

3 So the belly has been injured before, and it's
4 been injured in around the same location as it's injured
5 now.

6 Q But not around the same time?

7 A But not around the same time. And there's
8 much more extensive fresh injury where there was at
9 least from what was sampled, just one microscopic area
10 of old injury.

11 (Reported by D. Keith Johnson, CSR:)

12 Q Okay. But -- but hypothetically --

13 A Yes.

14 Q -- if the medical examiner's opinion is that
15 these injuries occurred around the same time, it's --

16 A You mean the old, the new?

17 Q Well, the injuries in the mesentery. If it's
18 his testimony or his opinion, hypothetically, that these
19 injuries occurred about the same time, in your opinion,
20 that would be incorrect?

21 MR. BINGHAM: I'm going to object to that
22 being an incorrect statement of his testimony.

23 MR. THOMPSON: Judge --

24 THE COURT: I'm going to let Mr. Thompson
25 go ahead. Put it in the form of a hypothetical without

1 leaving off any testimony. You can come back on
2 redirect.

3 Go ahead. If you've got a question --
4 say it again, Mr. Thompson. Let's go ahead and get to
5 it.

6 Q (By Mr. Thompson) If you have a medical
7 examiner -- this hypothetical medical examiner who
8 performed this autopsy and was -- had the hands-on
9 experience of looking at these injuries, this -- this
10 hypothetical board certified forensic pathologist, okay,
11 and it was his opinion that all of these mesentery
12 injuries occurred at or near the same time, in your
13 opinion, he would be incorrect?

14 A He would be incorrect as it applied to this
15 microscopic focus of old, organized hemorrhage with this
16 pigment that's there at that one site only, based on
17 what was sampled.

18 Q And if you were viewing -- hypothetically, if
19 you were reviewing microscopic slides that he had
20 prepared --

21 A But these are the slides he prepared.

22 Q Right, okay.

23 A Okay.

24 Q Then you would say that he missed that --
25 the -- the hypothetical board certified forensic

1 psychiatrist -- pathologist?

2 A But he didn't miss it. He sampled an area of
3 old injury with old hemorrhage. I mean, he didn't miss
4 it.

5 Q Okay. Listen to my question, okay?

6 A Okay.

7 Q Despite the sample, okay, if it's his
8 testimony, hypothetically, if he has done this
9 examination and this testing and has reached a
10 conclusion that all of these injuries occurred to the
11 mesentery at or about the same time, then based on your
12 observation of the samples that he provided, that would
13 be incorrect?

14 A It would be incorrect.

15 Q Okay.

16 A Because there is a focus of old injury there,
17 yes.

18 Q I think I missed it. I remember your
19 conversation with Mr. Bingham about the normal size of a
20 child's brain who's about two years old. And what did
21 you say that range of normality would be?

22 A And I'm going on my weight chart, which I
23 depend on for these things. But for a child of this
24 age, the weight would be about 1100 grams. And this
25 child's brain weight was -- well, I have the exact

1 weight. I just marked it on my -- is 1340 grams. And
2 that's -- that's about a 20 percent increase.

3 Q Could you see, from the autopsy photographs,
4 an abnormality in the brain?

5 A There was no blood described. And the
6 associated abnormality is brain swelling.

7 Q Well, was there anything about the brain lobes
8 or the brain tissues that told you that there was
9 swelling in the brain?

10 A The weight is your best way to know that the
11 brain is swollen.

12 Q So it's -- it's your conclusion that every
13 two-and-a-half-year-old child has a brain mass -- or
14 brain weight of 1100 grams?

15 A There's a little bit of range on that, but the
16 answer is yes. If the child is of appropriate stature
17 for age, the brain weight will be in a range around that
18 weight, that's correct.

19 Q What would the little bit of leeway be?

20 A That's a good question. Maybe up to five
21 percent.

22 Q Up to five percent?

23 A Yes.

24 Q So half of the difference?

25 A Not half. A quarter of the difference.

1 Q A quarter of the difference. What did you
2 say, 20 percent? So a quarter of the difference?

3 A Yeah. But for brain, that's significant.

4 Q Were there autopsy photos of the brain?

5 A You know, when you were asking me that, I was
6 trying to remember. And see, I don't have the -- the
7 photos with me, and I'm not remembering that. So --

8 Q Well, there's -- in the descriptive paragraph
9 that deals with -- you got a copy of the autopsy in
10 front of you?

11 A Yes, I do have the report.

12 Q In the descriptive information with respect to
13 the brain, there's nothing in that description that
14 indicates that there was a problem with the brain, is
15 there?

16 A Right. But that -- that's typical. If the
17 brain doesn't have tearing or hemorrhage, then it would
18 not -- or if it's not malformed. A lot of times the
19 appreciation of swelling is one based on weight rather
20 than appearance.

21 Q But there's nothing, even in the descriptive
22 paragraph with respect to the brain, that even alludes
23 to swelling.

24 A You're correct about that, sir, yes.

25 Q So this would just be another area where you

1 and Dr. Quinton disagree?

2 A It's an issue of disagreement. I would tell
3 you that in pediatric autopsy and pediatric pathology in
4 general, weights of organs and proportional weights of
5 organs, both proportional to age and proportional to the
6 other organs that are present are very important.
7 It's -- comparative organ weight is part of the
8 pediatric pathology assessment of organ growth and
9 development.

10 And for this child, the comparative organ
11 weights are all within range, except for the brain. And
12 the brain is way out of range. And it's significantly
13 heavy. I mentioned that it falls on the scale of about
14 an eleven-year-old. And that tells you that this brain
15 had too much weight. And the way a brain in an
16 otherwise normal child has too much weight is that it's
17 swollen. I mean, that's how the weight is acquired by
18 the brain.

19 Q Okay. But the report, on page 3 of the
20 report --

21 A I have that.

22 Q Despite your opinions about the weight --

23 A Yes.

24 Q -- the report says from the board certified
25 forensic pathologist who did this --

1 A Right, who is not a pediatric pathologist.

2 Q Right.

3 A Okay.

4 Q There are no epidural, subdural --

5 A Yes.

6 Q Sub --

7 A Subarachnoid, sir.

8 Q -- hemorrhages?

9 A Those are all different sites in the layers on
10 the surface of the brain, is what that refers to.

11 Q The cerebral hemispheres are symmetrical --

12 A Yes, sir.

13 Q -- with an unremarkable?

14 A Gyro.

15 Q -- gyro pattern?

16 A Yes, sir.

17 Q The cranial nerves and blood vessels are
18 unremarkable. The cerebral hemispheres, the brain stem,
19 and the cerebellum are unremarkable.

20 A And those are all -- are regions in the brain.

21 Q Yeah. Nothing there that suggests that
22 they're a little oversized or out of whack or --

23 A Or swollen.

24 Q -- or swollen. Nothing there to suggest that?

25 A I agree with what you just said. It's not in

1 there. But that's why the weight per child size and per
2 other organs become so important in making that
3 assessment.

4 MR. THOMPSON: May I have a moment, Your
5 Honor?

6 THE COURT: Yes.

7 Q (By Mr. Thompson) Thank you, Dr. Wilson.

8 MR. THOMPSON: Your Honor, we'll pass the
9 witness.

10 THE COURT: Thank you, Mr. Thompson.

11 THE WITNESS: Thank you, sir.

12 MR. BINGHAM: I have a few questions. It
13 will take just a minute.

14 Approach the witness?

15 REDIRECT EXAMINATION

16 BY MR. BINGHAM:

17 Q The other thing on page 46 that wasn't read to
18 you was, "So I'd say these injuries are within a day,"
19 right? This is Dr. Quinton's testimony right there.
20 You can see Dr. Quinton. He's saying, "So I'd say these
21 injuries are within a day. I don't think it's more than
22 that, because there would be a lot more organizational
23 change and inflammation.

24 "But, again, is it within a minute?

25 "No.

1 Then I ask a question, "How about within three
2 hours? Could that be possible?"

3 What does he say?

4 A Well, it says, "It's possible."

5 Q Let me talk about your --

6 MR. BINGHAM: May I approach the witness
7 again?

8 THE COURT: Yes.

9 Q (By Mr. Bingham) Let me show you this. You
10 see that has the same identifying tag on it -- see this
11 number down here, JP-1911-08?

12 A Yes.

13 Q Here's a photo of Kelynn. He has the same
14 number?

15 A Yes.

16 Q So you know that to be a picture of this area
17 here before it's been moved around, right?

18 A Yes, yes.

19 Q I mean, this is what you were trying to
20 describe to the jury when you had State's Exhibit 115
21 up, right?

22 A Yes. Yes, sir. This -- this makes the point
23 that what's happened is they've moved the bowel out of
24 the way and then flipped up the mesentery, yes.

25 MR. BINGHAM: Tender State's Exhibit 216

1 to defense.

2 MR. THOMPSON: May I have the witness on
3 voir dire?

4 THE COURT: Yes.

5 VOIR DIRE EXAMINATION

6 BY MR. THOMPSON:

7 Q With respect to the exhibit that's sitting up
8 there on the board, it looks like a portion of the liver
9 has been removed?

10 A Not removed, but -- but hidden by the -- the
11 mesentery that's flipped up.

12 Q The fact that the mesentery has been flipped
13 up?

14 A Yes.

15 Q So that photograph is an accurate depiction of
16 this photograph prior to moving the organ around?

17 A Right. In other words, that one was first,
18 and then this is after -- the one up here is after
19 manipulation.

20 MR. THOMPSON: I -- no objections.

21 THE COURT: All right. State's Exhibit
22 Number 216 is admitted into evidence with no objection.

23 MR. BINGHAM: Because it's small, can the
24 doctor be allowed to step down?

25 THE COURT: Yes, he can step down. Hand

1 him the microphone. I think he's got it up there. Like
2 I said, he had it up there. I think it's over here.

3 Doctor, you may step down around in front
4 of the jury. Just use the microphone where everyone can
5 hear you. Thank you.

6 REDIRECT EXAMINATION (CONTD)

7 BY MR. BINGHAM:

8 Q That photo, just so they understand, the
9 mesentery is where on this, before everything's moved
10 around so you can see the injuries?

11 Come over here, Doctor.

12 A Well, but you actually cannot see the
13 mesentery in that picture.

14 Q Exactly.

15 A The mesentery is in this picture.

16 Q Correct. And that's my point, is that in this
17 photograph, what is this up here?

18 A That's the liver. And I was describing the
19 fact that the liver extends from the right side over
20 past the midline, over to the left side. And it's below
21 the margin of the ribs.

22 Q Externally, where would the liver be in
23 this --

24 A It would be where this bluish area is.

25 Q So kind of like that right there?

1 A Well --

2 Q Like this?

3 A Yes. I mean --

4 Q And this photo in 215 is much -- is much
5 larger in size than 216?

6 A Well, without a scale, you really have to be
7 careful about that.

8 Q I understand. But just to show that this
9 bruise is going across the abdomen -- and here's the
10 liver before they flip it up to show the mesentery.

11 A Yes, yes.

12 Q Okay. Thanks, Doctor.

13 I'm going to skip a lot of these, because I
14 know your plane leaves in five minutes, so --

15 A JUROR: I don't think he's going to
16 make it.

17 Q (By Mr. Bingham) We changed it. But it's the
18 last flight out today at 5:30, so you have to leave here
19 about 4:30. So...

20 The last thing I'm going to ask you about is
21 brain weight. You have with you a -- a weight -- a
22 chart, do you not, that you rely on. What's that
23 called? Talking about brain weight.

24 A Well, this is -- what I'm looking at is an
25 organ weight chart. And there's a number of them, but I

1 like this one because it took a lot of data to create
2 this, the folks that did this.

3 Q And it's a chart that you rely on, and that's
4 part of -- when you look at the brain weight, the doctor
5 has removed the brain and weighed it, because you have
6 that in your autopsy report, right?

7 A That is correct, sir.

8 Q Dr. Quinton does not mention anything about
9 this being abnormal in his report to a child, that you
10 see.

11 A What he --

12 Q I'm sorry.

13 A Please explain what you're asking me.

14 Q Does he mention anywhere in his report that
15 the brain -- talking about the brain weight is abnormal
16 to indicate swelling, to indicate that this was not an
17 immediate death? Does he go through that analysis in
18 his report?

19 A No, not at all.

20 Q But that's significant to you as a pediatric
21 pathologist, is it not?

22 A Yes, it is. I mean, that's one of the things
23 that pediatric pathology pays a lot of attention to, is
24 not only the growth and development of the child as a
25 whole, but the growth and development of each organ,

1 each part. So you're trying to put all of that
2 together. And in a normally growing, healthy child,
3 these things are proportional and predictable. And when
4 there's something out of line in weight or developmental
5 features, then you need to explain why it's out of line.

6 And in this particular case, in the organ
7 weights, pretty much everything is in line except for
8 the brain, which is way out of line.

9 Q Which is another reason that pediatric -- you,
10 as a pediatric pathologist -- that's another reason why
11 pediatric pathology is so important in dealing with
12 child deaths?

13 A And it exists -- children are not small
14 adults. They're developing adults, but they're not
15 small adults.

16 Q And I'm going just going to touch on this
17 last. Mr. Thompson talks a lot about board certified
18 forensic pathologists. You, as a pediatric pathologist,
19 are -- well, you tell me. I know you don't like to do
20 this kind of thing. But are you actually more qualified
21 to conduct autopsies on children and determine --
22 interpret the injuries in these children than maybe a
23 forensic pathologist?

24 A Sir, I would -- I would not agree with the
25 concept of more qualified.

1 Q How would you call it?

2 A The way I would talk about this is that you
3 need to bring a combination of these disciplines to
4 understanding what is going on --

5 Q Okay.

6 A -- with a child. And that means perspective
7 on developmental medicine and developmental issues along
8 with the forensic science of injury.

9 I mean, there is no question that forensics
10 involves understanding nonnatural events that happens to
11 people, whether adults or children.

12 But there are special issues that relate to
13 children, because the organ systems, the tissues, the
14 developmental stage, and as in this case, the
15 relationship of the organ weight, something as simple as
16 that, becomes very important to know that something is
17 out of kilter.

18 And for me, every autopsy I do on a child, I
19 have a standard set of weights -- or the predicted
20 weights of a child of a certain age and size. And if an
21 organ is too big or too little, you have to account for
22 why that is.

23 And sometimes it's for developmental reasons;
24 sometimes for disease. In this case, the organ of the
25 brain is too large because it is swollen in this child

1 before the child died. And that tells you something
2 about the fact that the death was not an instantaneous
3 death nor was it even a rapid death, but it was a
4 lingering death, for it takes time for brain swelling to
5 manifest itself.

6 Q And based on your interpretation of the -- the
7 sites of the slides, you believe that that was less than
8 four hours; is that correct?

9 A The -- now, that's --

10 Q From time of impact to death?

11 A Yeah. That -- well, we're talking multiple
12 impacts here. But that's a process that is put into a
13 timeframe because of the tissue reactivity that has not
14 occurred.

15 In other words, there's blood, but there's
16 little reaction to the blood. And the brain has had
17 time to swell, but the blood has not had time to
18 transform. And so you use those things to put within a
19 time range. And a time range of two to four hours is
20 not -- is not unreasonable in looking at what happened
21 to this child.

22 Q Okay. And one last --

23 MR. BINGHAM: May I approach?

24 Q (By Mr. Bingham) If we look at those slides --
25 just forgive me, but which slide was it that you were

1 just talking about? Was it this one right here?

2 A No --

3 Q That was talking about that they had not had
4 time to really react to the blood, what you just said.
5 Which slide -- I know these are different slides. These
6 are of the mesentery and this is -- these are of the
7 ribs, right?

8 A Well --

9 Q State's Exhibit 212 and 211.

10 A Right. Now, that's the rib, and that's a
11 different issue that we've talked about.

12 Q 209 and 210?

13 A Now, that's -- the -- the one with the iron is
14 a site of old hemorrhage for which there has been
15 prominent iron deposition, but you don't see that at
16 other places in the slides. So that's the coexistent
17 old hemorrhage site in the mesentery.

18 But this is more the fresh hemorrhage in that
19 the cells are well preserved and there's -- there's not
20 the apparent presence of iron.

21 Now, we use an iron stain to turn iron blue,
22 but you don't need a blue iron stain to see iron. It's
23 kind of a golden hue, and there's none of that in the
24 slide in which --

25 Q In State's 209?

1 A Yes.

2 Q In State's Exhibit 209, okay.

3 And this is where you look at -- you say
4 this -- that there is a new injury, multiple impacts
5 that for the mesentery occurred in a timeframe from
6 point of impact to death of somewhere between two and
7 four hours?

8 A Now --

9 Q As a range.

10 A As a range. But you have to understand that
11 the most important thing is the story.

12 Q Sure.

13 A And the verifiable historical events. And if
14 you have a child who by multiple observers is functional
15 and not in a state of dwindle or a coma, then the
16 injury hasn't occurred yet.

17 And we have a story during this timeframe
18 also, these last four hours, given by one person.

19 Q Talking about the defendant's statements?

20 A Yes.

21 Q Okay.

22 A But the story of the child being functional,
23 if -- if that is to be believed, actually would state
24 that the child still hadn't been injured under -- under
25 this person's care.

1 Q What the defendant is saying is either the
2 child's not been injured yet, which we know he's dead at
3 12:56 -- or he's been injured and the defendant's lying
4 about it?

5 A That's correct.

6 Q Okay. Thank you.

7 MR. BINGHAM: We'll pass the witness,
8 Judge.

9 THE COURT: Okay, Mr. Bingham.
10 Mr. Thompson, anything else?

11 MR. THOMPSON: Yes.

12 THE COURT: Okay.

13 RE CROSS-EXAMINATION

14 BY MR. THOMPSON:

15 Q So there's -- there's -- if I understand --
16 understood your earlier testimony, the injury that this
17 child suffered would have interfered with his ability to
18 eat or to consume food or to drink liquids and that
19 would have been almost immediately after injury?

20 A That is correct, after this -- this beating
21 event occurred.

22 Q Okay.

23 A JUROR: Can you use the mic.?

24 Q (By Mr. Thompson) And your opinion is -- let
25 me ask you this: What if you had a story that during

1 the period of time that this child was injured, that he
2 was functioning normally? In your opinion that,
3 wouldn't be possible?

4 A That would be a bogus story with these
5 injuries.

6 Q Are you talking about the extent of these --
7 are you talking about the extent of these injuries that
8 the child suffered in this case, or are you talking
9 about mesentery injuries in general?

10 A No. The injuries that this child has in this
11 case.

12 Q What is it about these injuries that would
13 have prevented the child from functioning normally?

14 A The irritation -- first of all, the trauma
15 itself that caused the tearing of the mesentery, the
16 blood that's there that causes the irritation. Blood in
17 the peritoneal cavity is painful and irritating. And
18 when this child received the blows that created this,
19 this child would have been down, would not have been
20 functional following that.

21 Q Would never have been able to get up and
22 function in a normal manner?

23 A Not -- not carrying the blood and the tears in
24 the mesentery that we see on these pictures.

25 Q In the article that you coauthored on

1 page 484 -- do you have the book up there?

2 A Yes, I do, sir. Just one moment. Okay.

3 Q On the second -- well, actually it's the first
4 full paragraph on the right-hand column.

5 A Okay.

6 Q Where it says, "Unlike fatal head trauma, in
7 which significant symptoms develop immediately, a child
8 with an abdominal trauma may appear relatively symptom
9 free for several hours after injury. An immediate
10 response to the pain of the infliction -- inflicted
11 injury will have occurred, but often will not be
12 reported. The onset of serious abdominal symptoms may
13 be insidious, particularly in the preverbal child, and
14 is characteristic of injuries such as duodenal
15 perforation or other retroperitoneal injury. The child
16 with an injury such as a small liver or mesenteric
17 laceration also may initially appear relatively
18 asymptomatic."

19 Doesn't "asymptomatic" mean that he would show
20 virtually no symptoms of injury?

21 A Yes. That is correct.

22 Q Would persistent slow accumulation of blood
23 over a period of time -- a slow -- is that what slow
24 accumulation of blood means?

25 A That's correct.

1 Q Okay. In the abdominal cavity until collapse
2 suddenly occurs due to -- what is that?

3 A Due to shock.

4 Q Okay.

5 A A decreased blood volume related shock.

6 Q Due to shock?

7 A Yes.

8 Q Okay. And you're saying that the -- the
9 maximum period of time in a mesentery tear involving the
10 small blood vessels, such as this child sustained, would
11 be only four hours?

12 A That's correct.

13 Q And that he would be showing symptoms
14 immediately?

15 A He would show symptoms immediately from the
16 effect of the trauma that brought about the tear and
17 then the effect of the blood itself, the blood being
18 very irritating and causing him not to be able to eat,
19 not to be able to function, having bowel discomfort,
20 maybe nausea and vomiting going along with that.

21 Q And you would --

22 A And it's the free blood that creates that
23 problem.

24 Q And it would be your testimony -- well, all
25 mesentery -- do all mesentery tears result in free

1 blood?

2 A Yes, by just the nature of being a tear, yes.

3 Q Okay. And it's your testimony that all
4 people -- all individuals, children or adults, who
5 suffer this kind of injury, are going to react the same
6 way?

7 A Well, there's clearly individual variation.
8 And, you know, if you had -- the difference is that if
9 you have a hematoma, where you have an injury and the
10 blood is confined, say, on the surface of the bowel,
11 that can have a more delayed effect. But free blood in
12 the abdomen, as we have in this case, even in low
13 quantities, causes discomfort and irritation that can be
14 significant.

15 And this is one of the effects that women
16 under going ovulation experience. There's actually a
17 term for the phenomena of having ovulation pain, which
18 really relates to the small release of blood into the
19 abdominal cavity. And that can be very annoying and
20 disturbing to the person experiencing it.

21 It doesn't incapacitate them, but they're
22 aware that they have pain. And when you have pain from
23 the trauma that -- that tore vessels that allows for
24 this slow leaking of blood in a young child, that's
25 going to make that child be out of sorts significantly

1 once that tear has -- or tear sites have occurred.

2 Q And every injury of this nature is going to
3 affect every child the same way?

4 A No. Again, you're right -- I mean, there's
5 individual variation. Clearly that does occur, and some
6 people are more tolerant of pain than others.

7 But there's going to be the perception that
8 the child is no longer well, and that means not eating
9 and moaning and being --

10 Q Whimpering?

11 A Whimpering, yes.

12 Q Clingy?

13 A Yes, those things.

14 Q Not eating -- not eating -- not a normal
15 eating pattern?

16 A Yes.

17 Q Not being as active as he normally would be?

18 A Right. And not --

19 Q Even up until the time that he loses
20 consciousness?

21 A That's correct, yes.

22 Q Craving -- being thirsty, whether he
23 regurgitates or not after he drinks, but he would have
24 the feeling of thirst?

25 A Yes.

1 Q And because of the bloating in his stomach and
2 his abdomen area, he could have the feeling of hungry,
3 even though he doesn't eat?

4 A Those -- those are reasonable descriptions,
5 yes.

6 Q And it's your opinion that if a child suffered
7 this kind of injury and lives for days, as I think
8 Dr. Quinton said that he had seen cases of, then these
9 would be children who would be hidden out somewhere not
10 eating, not drinking for days, until -- and they would
11 be hid away in a closet somewhere -- or a room somewhere
12 until they just die?

13 A Yes.

14 Q These would not be children that would be out
15 in the public walking around?

16 A That's correct, sir.

17 Q Okay.

18 MR. THOMPSON: That's all I have. Pass
19 the witness.

20 MR. BINGHAM: I've got two questions.

21 REDIRECT EXAMINATION

22 BY MR. BINGHAM:

23 Q The mesentery tear that may be asymptomatic is
24 not to the degree that Kelynn Pinson's mesentery tear
25 was?

1 A Actually, in that case, it's not an issue of
2 mesenteric tear as a confined hematoma.

3 Q Okay.

4 A See, it's the issue of having free blood in
5 the abdomen that causes you problems.

6 Q Okay.

7 A And this is why I mentioned the experience
8 related to the menstrual cycle in women. Because some
9 women are exquisitely bothered by ovulation with even
10 the small amount of free blood that gets entered into
11 the abdominal cavity.

12 Q Because I think -- someone may ask, well, if
13 you're writing on page 484 that someone can have a
14 mesentery tear and may be asymptomatic, how come Kelynn
15 Pinson couldn't be asymptomatic? Do you see what I'm
16 saying?

17 A Right. Yeah, but what I'm talking about there
18 is confined blood. If there's -- mesenteric blues is
19 really what that would be referring to.

20 Q Okay. So when you're talking about may be
21 asymptomatic, you're referring to the type of injury
22 that is what? I'm just not -- that it's like a --

23 A A bruise and not overt bleeding, you know, in
24 the abdomen.

25 Q Okay. If you have free blood in the

1 abdomen --

2 A That's very irritating.

3 Q Okay. So that's -- let me -- do you have your
4 article? Let me see it real quick.

5 Show me on here -- and I'm going to -- because
6 I have not actually had a chance to read your article.

7 Right here where it says -- where was he
8 reading from?

9 A Page 484.

10 Q Okay. What does it say?

11 A (Indicating.)

12 Q Okay. "A child with abdominal trauma may
13 appear relatively symptom free for several hours and
14 immediate response to the pain of the inflicted injury
15 will have occurred but often not reported."

16 Where does it get into the mesentery?

17 A Well, I mean, it's talking about that it can
18 be much more insidious with the abdominal symptoms that
19 are there.

20 Q Where does it talk in here -- where does it
21 say mesentery tear? Where --

22 A I mean, it's really duodenal perforation or
23 other retroperitoneal injury. It's kind of covering
24 that. But, see, one of the things that happens with
25 these injuries is that they evolve over time, and

1 especially if initially there's not blood, or there's
2 just confined blood, there can be a delayed effect as
3 the tissue breaks down and then either starts bleeding
4 or you get abdominal perforation that comes.

5 And so you can have an event which is
6 insidious in that there can be a delayed effect of more
7 significant organ injury.

8 But in this case, we have the rapid onset of
9 abdominal tearing -- of the tissue tearing.

10 Q I see. So if it is confined -- if you have
11 the free blood is where then you get -- you get into the
12 problems of not being able to function?

13 A Free blood in the abdomen is -- is very
14 painful and very disturbing.

15 Q Okay. Let me ask you one other thing, because
16 this is -- before I let you go, I need to ask you -- say
17 the child went to -- you have children, do you not? Do
18 you have children?

19 A Four children, yes.

20 Q Four children. There are some times that
21 children are hungry or not. Have you ever said to your
22 child, "This is dinnertime. If you don't eat now,
23 that's it"? Have you ever said that to your child?

24 A I don't know about the "that's it" part.

25 Q I really wasn't trying to trick you.

1 Okay. In other words, you want them to eat
2 then, right?

3 A For -- let's say for our own convenience, yes.

4 Q Yeah, for our own convenience. Sometimes
5 children eat; sometimes they don't want to eat, right?
6 If you're hungry sometimes doesn't mean you're hungry
7 all the time, right?

8 Now, let's assume -- let's not even try to
9 attach a reason to it. If the child doesn't eat here --
10 because sometimes not eating could be an indication of
11 abdominal trauma?

12 A Absolutely, yes.

13 Q Well, if he doesn't eat here, but then he goes
14 over here and he eats all of this, then where -- then
15 what?

16 A Well, there's not free blood in the abdomen,
17 and he's not been punched in the abdomen.

18 Q Right. I mean, you can't -- you can't isolate
19 this incident and say, okay, he's not eating here and
20 disregard the future history, right?

21 A I agree.

22 Q And also at the later time right here, there's
23 no free blood in his abdomen right here, you can tell,
24 because -- what you're saying is, is he's eating, he's
25 walking to the mailbox, he's scooting himself on a Big

1 Wheel, then -- and he has no signs of distress and he
2 takes a bath at 11:00, there's no bruise, everyone
3 thinks he's normal, then all of that is consistent with
4 him having no free blood in the abdomen?

5 A His belly hasn't yet been battered.

6 Q Thank you. Thank you.

7 MR. BINGHAM: We pass the witness.

8 RE CROSS-EXAMINATION

9 BY MR. THOMPSON:

10 Q In the article that we were just talking about
11 on page 484 --

12 A Yes, sir.

13 Q -- in that paragraph --

14 A Yes, sir.

15 Q -- you do see where it talks about mesenteric
16 lacerations?

17 A In that same paragraph?

18 Q Yeah, in that same paragraph. "The child with
19 an injury such as a small liver or mesenteric
20 laceration." It doesn't say a bruise to the mesentery.
21 It doesn't say, you know, a -- it says "mesentery
22 laceration."

23 A No. You're correct, sir, yes.

24 Q Okay. A tear?

25 A Yes.

1 Q Where it's going to bleed?

2 A Where it's going to bleed, right.

3 Q Okay. And then it says that may be
4 asymptomatic?

5 A With the slow accumulation of blood.

6 Q So based on your -- the conclusions you've
7 drawn, the person who wrote this part of this article --
8 obviously you didn't write this, right? Because you
9 wouldn't have put it like that.

10 A I -- I agree with this. This is relating,
11 again, to the fact that initially, with a little amount
12 of blood, you -- you may not have major symptoms. But
13 with the accumulation of blood and even the amount that
14 we have in this child, you would have major symptoms.
15 You would not --

16 Q But didn't you just say a few minutes ago that
17 any amount of blood free flowing in the abdomen is going
18 to cause you irritation?

19 A Yes. But --

20 Q That's why women feel so bad when they're
21 having their cycle. I mean, despite the fact that women
22 go skiing, swimming, play tennis, you know, while
23 they're having their cycle -- some women do -- you know,
24 despite that, but any free-flowing blood in the
25 abdomen -- you didn't say a little bit of free-flowing

1 blood was okay. You said any free-flowing blood in the
2 abdomen is going to incapacitate you to the point where
3 you can't do nothing, and you're just going to be laying
4 there dead or put away in a room somewhere not eating
5 for days until the child dies.

6 A If I conveyed that, that's a little bit
7 extreme. But any blood -- any blood in the abdomen is a
8 source of irritation to the person that has the blood.

9 MR. THOMPSON: That's all I have, Judge.

10 THE COURT: All right, Mr. Thompson.

11 Mr. Bingham.

12 MR. BINGHAM: No, Judge. Thank you.

13 THE COURT: And I take it that the doctor
14 may be finally excused as a witness?

15 MR. BINGHAM: Can I ask Mr. Thompson
16 something?

17 THE COURT: Sure.

18 (Counsel confer.)

19 MR. BINGHAM: Judge, we -- we rest. We'd
20 rest.

21 THE COURT: All right. As far as the
22 doctor goes, may he be finally excused?

23 MR. BINGHAM: Sure.

24 THE COURT: Get him on the road to the
25 airport? Finally excused?

1 MR. THOMPSON: No objections.

2 THE COURT: Doctor, you're finally
3 excused as a witness. Have a safe trip back. Thank you
4 for being here.

5 (The witness left the courtroom.)

6 THE COURT: All right. Mr. Bingham, did
7 you just rest?

8 MR. BINGHAM: We did.

9 THE COURT: All right. You rest, Mr.
10 Thompson, you rest and close now?

11 MR. THOMPSON: Defense closes.

12 THE COURT: All right. Ladies and
13 Gentlemen, with both the State and defense having rested
14 and closed the cases, let me explain to you from a
15 procedural standpoint what takes place next.

16 First of all, you're going to get to
17 leave. But after -- that's the good part. After you
18 leave, what we're going to be doing is working on what
19 we call the Charge of the Court. We've already done
20 some work on it, but it really can't be finalized until
21 we finish all of the evidence in the case. We'll be
22 working on the Charge of the Court for some time, for
23 some time here, and then also in the morning.

24 When you come back in the morning -- I'm
25 going to give you a time in just a minute after I confer

1 with counsel. But when you come back in the morning --
2 when you come in the courtroom, first thing that will
3 take place is I will read the Charge of the Court to
4 you.

5 The Charge of the Court contains all of
6 the instructions on the law that you will follow in
7 deliberating the evidence and arriving at your verdict
8 in the case. But after I read the charge of the Court
9 to you, which will be fairly lengthy, you're going to
10 hear final argument from the State, arguments from the
11 defense, and closing arguments from the State. That
12 will take us a certain period of time, which we'll
13 decide on this evening.

14 After the charge is read and you hear
15 arguments from counsel, then the case will be submitted
16 to you for your deliberation.

17 I'm going to give you -- if you'll bear
18 with me just a moment, because this charge we're
19 working -- going to be working on after you leave.

20 Counsel, let me see you at the bench.

21 (Bench conference:)

22 THE COURT: I mean, we're going to stay
23 this evening --

24 MR. BINGHAM: Right.

25 (Counsel confer.)

1 MR. BINGHAM: How about 10:00? Well, I
2 mean --

3 THE COURT: We're going to have --

4 MR. THOMPSON: 10:00, sure, would be
5 wonderful, Judge.

6 THE COURT: Sure would be wonderful,
7 but -- not always that way.

8 (End of bench conference.)

9 (Reported by Steve R. Awbrey, CSR:)

10 THE COURT: All right. Ladies and
11 gentlemen, what I'm going to ask you to do and this is a
12 little bit later, but the reason is, where I can be sure
13 when you come in we'll be ready to charge and argue the
14 case. I'm going to ask you in the morning to be back at
15 9:30. Okay?

16 And bear in mind all of the instructions.
17 We're getting down to the point where the case is going
18 to be submitted to you for your deliberations, and
19 verdict. We'll see you at 9:30 in the morning in the
20 jury room.

21 All rise for the jury.

22 (The jury left the courtroom.)

23 THE COURT: We're back on the record in
24 Cause Number 241-1251-08; State Texas versus Demontrell
25 Miller.

1 State's counsel is present. Defense
2 counsel's present. The defendant is present. We're
3 outside the presence of jury on the charge conference.

4 Now, the charge the Court has capital
5 murder, all of the lesser included's requested,
6 obviously, the charge on capital murder. This charge
7 that the Court has charges on murder under 19.02(2)
8 which is in paragraph 5.

9 Okay. Let me get what Mr. Thompson -- go
10 ahead and put on the record what you are requesting on
11 the lesser included's. We're on the record now.

12 MR. THOMPSON: Judge, the only thing
13 we're asking as far as lesser included offenses are
14 concerned is felony murder 19.02(b)(2) and criminally
15 negligent homicide.

16 THE COURT: What's the State's position?

17 MR. BINGHAM: Judge, our position is we
18 will agree to include felony murder under 19.02(b)(2) as
19 a lesser included offense. For the record under the
20 Lofton standard, Felder versus State, and Nelson
21 Aramando Paz versus State, we don't think they're
22 entitled to it, but we will agree to it.

23 We definitely disagree with criminally
24 negligent homicide, because of the standard set forth in
25 the Lofton case. Lofton versus State, Court of Criminal

1 Appeals case 45 SW 3d 649.

2 That the defendant under the standard
3 whereby it says a defendant either presents evidence
4 that he committed no offense or presents no evidence,
5 and there's no evidence otherwise showing that he's
6 guilty only of the lesser included offense.

7 Additionally, there's a no evidence
8 establishing if the defendant is guilty, he's guilty
9 only of criminally negligent homicide.

10 Therefore, we will agree even though we
11 don't think he's entitled to it, we will agree to the
12 felony murder. We object to criminally negligent
13 homicide for the reasons just set forth.

14 THE COURT: All right, Mr. Thompson?

15 MR. THOMPSON: We don't have anything
16 else, Judge.

17 THE COURT: I'm sorry?

18 MR. THOMPSON: We don't have anything
19 else.

20 THE COURT: Okay. Well, the Court is
21 going to deny your request for a lesser included offense
22 for a charge on the lesser included offense of
23 criminally negligent homicide.

24 Mr. Thompson, one of y'all, while we are
25 still on the record, since I'm going to submit the

1 19.02(2) which is in paragraph -- my question is there
2 any objection to how I have it in the charge in 5,
3 paragraph 5? It's in 5, but if each of would you look
4 at it.

5 MR. THOMPSON: I don't see any problem,
6 Judge, with the way that is.

7 THE COURT: Let's see what they have to
8 say.

9 If you want to, we can just get back down
10 here at 8:30 in the morning. I know where I am in terms
11 of finalizing it. If you want to go on, Ms. Lacy. Why
12 don't you just go on. Mr. Miller, you can go on, too.
13 Take him on back, and I'll finalize it at 8:30 in the
14 morning.

15 Y'all be back at 8:30.

16

17 (Recess for day.)

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1 STATE OF TEXAS *

2 COUNTY OF SMITH *

3 We, STEVE R. AWBREY, CSR, Official Court
4 Reporter, and D. KEITH JOHNSON, CSR, RDR, CRR, Deputy
5 Official Court Reporter for the 241st Judicial District
6 Court in and for Smith County, Texas, do hereby certify
7 that the above and foregoing contains a true and correct
8 transcription of all of the portions of evidence and
9 other proceedings requested in writing by counsel for
10 the parties to be included in this volume of the
11 Reporter's Record, in the above-styled and numbered
12 cause, all of which occurred in open court or in
13 chambers and were reported by us.

14 We further certify that this Reporter's Record
15 of the proceedings truly and correctly reflects the
16 exhibits, if any, offered by the respective parties.

17 WITNESS OUR OFFICIAL HANDS this the 3rd day of
18 November, 2009.

19

20 STEVE R. AWBREY

TX CSR #3940

21 Expires: 12-31-09

Official Court Reporter

22

D. KEITH JOHNSON

TX CSR #3781

Expires: 12-31-09

Deputy Official Reporter

23

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